AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

IN THE HANDS OF STRANGERS: ARE NURSING HOME SAFEGUARDS WORKING?

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

MAY 15, 2008

Serial No. 110–116

Printed for the use of the Committee on Energy and Commerce

energycommerce.house.gov

IN THE HANDS OF STRANGERS: ARE NURSING HOME SAFEGUARDS WORKING?

IN THE HANDS OF STRANGERS: ARE NURSING HOME SAFEGUARDS WORKING?

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

MAY 15, 2008

Serial No. 110–116

Printed for the use of the Committee on Energy and Commerce

energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE

54–591 PDF WASHINGTON : 2008

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

COMMITTEE ON ENERGY AND COMMERCE

JOHN D. DINGELL, Michigan, *Chairman*

HENRY A. WAXMAN, California
EDWARD J. MARKEY, Massachusetts
RICK BOUCHER, Virginia
EDOLPHUS TOWNS, New York
FRANK PALLONE, JR., New Jersey
BART GORDON, Tennessee
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
BART STUPAK, Michigan
ELIOT L. ENGEL, New York
ALBERT R. WYNN, Maryland
GENE GREEN, Texas
DIANA DEGETTE, Colorado
Vice Chairman
LOIS CAPPS, California
MICHAEL F. DOYLE, Pennsylvania
JANE HARMAN, California
TOM ALLEN, Maine
JAN SCHAKOWSKY, Illinois
HILDA L. SOLIS, California
CHARLES A. GONZALEZ, Texas
JAY INSLEE, Washington
TAMMY BALDWIN, Wisconsin
MIKE ROSS, Arkansas
DARLENE HOOLEY, Oregon
ANTHONY D. WEINER, New York
JIM MATHESON, Utah
G.K. BUTTERFIELD, North Carolina
CHARLIE MELANCON, Louisiana
JOHN BARROW, Georgia
BARON P. HILL, Indiana

JOE BARTON, Texas
Ranking Member
RALPH M. HALL, Texas
FRED UPTON, Michigan
CLIFF STEARNS, Florida
NATHAN DEAL, Georgia
ED WHITFIELD, Kentucky
BARBARA CUBIN, Wyoming
JOHN SHIMKUS, Illinois
HEATHER WILSON, New Mexico
JOHN B. SHADEGG, Arizona
CHARLES W. "CHIP" PICKERING, Mississippi
VITO FOSSELLA, New York
STEVE BUYER, Indiana
GEORGE RADANOVICH, California
JOSEPH R. PITTS, Pennsylvania
MARY BONO MACK, California
GREG WALDEN, Oregon
LEE TERRY, Nebraska
MIKE FERGUSON, New Jersey
MIKE ROGERS, Michigan
SUE WILKINS MYRICK, North Carolina
JOHN SULLIVAN, Oklahoma
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee

PROFESSIONAL STAFF

DENNIS B. FITZGIBBONS, *Chief of Staff*
GREGG A. ROTHSCHILD, *Chief Counsel*
SHARON E. DAVIS, *Chief Clerk*
DAVID L. CAVICKE, *Minority Staff Director*

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

BART STUPAK, Michigan, *Chairman*

DIANA DeGETTE, Colorado
CHARLIE MELANCON, Louisiana
Vice Chairman
HENRY A. WAXMAN, California
GENE GREEN, Texas
MIKE DOYLE, Pennsylvania
JAN SCHAKOWSKY, Illinois
JAY INSLEE, Washington
JOHN D. DINGELL, Michigan *(ex officio)*

ED WHITFIELD, Kentucky
Ranking Member
GREG WALDEN, Oregon
MIKE FERGUSON, New Jersey
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee
JOE BARTON, Texas *(ex officio)*

CONTENTS

	Page
Hon. Bart Stupak, a Representative in Congress from the State of Michigan, opening statement	1
Hon. John Shimkus, a Representative in Congress from the State of Illinois, opening statement	3
Hon. John D. Dingell, a Representative in Congress from the State of Michigan, prepared statement	5
Hon. Marsha Blackburn, a Representative in Congress from the State of Tennessee, opening statement	7
Hon. Gene Green, a Representative in Congress from the State of Texas, opening statement	8
Prepared statement	9
Hon. Michael C. Burgess, a Representative in Congress from the State of Texas, opening statement	10
Hon. Joe Barton, a Representative in Congress from the State of Texas, prepared statement	12
Hon. Jan Schakowsky, a Representative in Congress from the State of Illinois, prepared statement	204

WITNESSES

Lewis Morris, Chief Counsel to the Inspector General, Office of the Inspector General, U.S. Department of Health and Human Services	13
Prepared statement	16
Richard Blumenthal, Attorney General, State of Connecticut	32
Prepared statement	35
Susana Aceituno	52
Prepared statement	54
Thomas DeBruin, president, Pennsylvania Service Employees International Union	86
Prepared statement	88
David Zimmerman, Ph.D., director, Center for Health Systems Research and Analysis, University of Wisconsin-Madison	93
Prepared statement	95
Andrew Kramer, M.D., head, professor of medicine, Division of Health Care Policy and Research, University of Colorado-Denver	103
Prepared statement	105
Neil L. Pruitt, Jr., chairman and chief executive officer, UHS-Pruitt Corporation	121
Prepared statement	124
Mary Jane Koren, M.D., M.P.H., assistant vice president, The Commonwealth Fund	137
Prepared statement	140
Kerry Weems, Acting Administrator, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services	183
Prepared statement	185
Answers to submitted questions	210

SUBMITTED MATERIAL

Presentation accompanying Dr. Koren's testimony	148
Haven Nursing Facilities and Affiliated Entities Organizational Chart	206
Definitions of terms used in hearing	208
Chart entitled, "CMS Nursing Home Quality Milestones, 2007-2008"	209
Subcommittee exhibit binder	223

IN THE HANDS OF STRANGERS: ARE NURSING HOME SAFEGUARDS WORKING?

THURSDAY, MAY 15, 2008

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:03 a.m., in room 2123 of the Rayburn House Office Building, Hon. Bart Stupak (chairman) presiding.

Members present: Representatives Stupak, Green, Schakowsky, Dingell (ex officio), Shimkus, Whitfield, Walden, Murphy, Burgess, Blackburn, and Barton (ex officio).

Staff present: Scott Schloegel, John Sopko, Kristine Blackwood, Michael Heaney, Voncille Hines, Kyle Chapman, Alan Slobodin, Peter Spencer, and Whitney Drew.

Mr. STUPAK. This meeting will come to order.

Today we have a hearing entitled "In the Hands of Strangers: Are Nursing Home Safeguards Working?"

Each member will be recognized for an opening statement. I will begin.

OPENING STATEMENT OF HON. BART STUPAK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. STUPAK. This is National Nursing Home Week, which makes today's hearing quite timely. Surprisingly, this subcommittee has not held an oversight hearing on nursing home care since 1977. The make-up of the nursing home industry and its clientele has radically changed over the past 31 years.

The last significant change in nursing home regulations came 21 years ago in the Nursing Home Reform Act, which was passed as part of the Omnibus Budget Reconciliation Act of 1987, or OBRA 87. In that act, Congress established standards for quality of care and quality of life that nursing homes must meet in order to receive payment from Medicare and Medicaid. Now, 21 years later, we are examining whether these standards continue to provide an appropriate level of patient care and protect the residents of nursing homes.

Some of our most frail, elderly, disabled citizens live in nursing homes either for a short time for rehabilitation or for long periods, when it becomes their final resting home. Many are completely dependent on others for everything from eating to bathing, turning them over in bed, and pain management. Government regulations require that a base level of care be provided to nursing home resi-

dents, not only because this vulnerable population cannot speak for themselves but also because taxpayer-funded programs like Medicaid and Medicare pay for the vast majority of the care provided at nursing homes.

The Centers for Medicare and Medicaid Services, CMS, enforces these minimum standards by contracting with each state to conduct annual inspections or surveys of nursing homes. If state surveyors identify a problem, called a deficiency, they can recommend various sanctions to CMS, ranging from civil monetary penalties to the rarely used ultimate sanction of termination from participation in the Medicare and Medicaid programs. CMS and state surveyors strive hard to look beyond a nursing home's walls to see whether the fragile nursing home residents are receiving all the care they need. However, surveys often fail to identify serious problems that threaten residents. Moreover, when the surveyors do identify problems, the penalties imposed by CMS can be so weak that they fail to bring about sustainable improvement in the practices of the facilities.

The day-to-day responsibility for the difficult task of care in nursing homes falls on dedicated and hardworking nurse aides, skilled nurse professional and industry owners and operators. We entrust our loved ones often only as a last resort to the hands of these strangers to care for our grandparents and parents. In most cases, these strangers become a second family for us and our loved one, and they care for our family member with the same love and attention as if he or she were part of their own family. These dedicated, devoted caregivers and many of the companies that employ and manage them deserve our profound thanks for their commitment and leadership in the daunting task of caring for an increasingly fragile and medically complex patient population.

In the past few years, a wave of new owners and investors have begun purchasing nursing home chains, both small and large, successful and unsuccessful chains. These firms are private, unregulated, and new to the nursing home market. Many worry that the top priority for these new owners will be profits rather than providing for staffing and resources necessary to ensure top quality care for our loved ones. Frequently, they use complex corporate structures separating the nursing home real estate from the operating companies and putting multiple layers of limited liability partnerships between themselves and the day-to-day operations of the nursing home.

The impact of these new owners on the quality of care and safety of nursing home residents is still unclear. Some companies reinvest their profits into the facilities and focus on quality of patient care. Others unfortunately skim off the profits to line the pockets of investors or plow the money into separate ventures that have nothing to do with nursing home care. What is certain, however, is that CMS and the States lack the tools to keep up with the rapid change in the industry, to know who actually owns the country's nursing homes and who should be held accountable for residents in their care.

When Congress passed the OBRA 87 safeguards, the typical nursing home was owned by a sole proprietor or family and not part of a chain. Now over 50 percent of nursing homes are part of

a chain and many of those are in the hands of private equity investors. Chain ownership has the potential to improve quality of care by allowing the sharing of resources and expertise across their facilities. At the same time, chains have the potential to hide common problems and obscure responsibility for inadequate care. The Centers for Medicare and Medicaid Services, CMS, needs to weigh these concerns to a greater degree in its enforcement.

Today's hearing will examine the challenges posed for the Federal, State, and local government, individual families, resident advocates and family members and the industry as the face of nursing home ownership rapidly changes. We will hear from witnesses reflecting a variety of perspectives including government leaders, academic experts, industry leaders, and organized labor representing nursing home workers, and the Centers for Medicare and Medicaid Services. We will also hear an example of a troubled nursing home chain in New England whose homes have been fined more than 45 times in the last 3 years for patient care problems that have had tragic results such as organ failure, amputation of limbs, paralysis, and death. The chain is now in bankruptcy and on the brink of sale to a private equity firm. Clearly, this example is the exception rather than the rule when it comes to nursing home care. Our goal here today is to be sure that these such examples become more and more rare or disappear altogether.

I look forward to hearing from our witnesses today. We owe this hearing to the industry, nursing home staffs and the nursing home residents to ensure that Congress is doing all we can to see that Federal nursing home regulations are adequate.

Mr. STUPAK. I would now like to now turn to my colleague, Mr. Shimkus, for his opening statement.

Before I do so, we should take note of the fact that Mr. Shimkus retired last night after 32 years of service in the military in the Army as a ranger, and I want to thank him for his service to our country, and I really do enjoy having him as my ranking member and a friend, but thank you for your service to our country, John, and look forward to your opening statement.

OPENING STATEMENT OF HON. JOHN SHIMKUS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. SHIMKUS. Thank you, Mr. Chairman. Thank you for coming last night, and the flashback was 1977. I was a freshman at West Point, so 31 years ago was the last time we had a hearing on this industry, and that is too long and so it is appropriate that we do this.

Today's hearing will expose the issues and practices surrounding the critical Federal safeguards for ensuring quality of care at nursing homes across the country. This bipartisan oversight examination is necessary to ensure these safeguards are up-to-date and effective.

Today's hearing topic is an intensely personal one for many people. Many Americans already or will have to entrust a mother, father or spouse— for me, grandparents—at certain times of their life at the most vulnerable to the care of a nursing home. In fact, my grandmother was a dementia patient and was in 10 years before she passed away, and I remember that well. When entrusting

our most vulnerable citizens, our loved ones, to the care of strangers, there is a fundamental need to know that they are in good hands.

The nursing home industry is a complex and diverse industry extending to some 16,000 individual facilities, serving 3 million people per year. This industry has been rapidly changing over 2 decades, and the question is: how have these changes affected the quality of care?

From the available evidence, improvements in nursing home quality have improved in some ways over the past 2 decades but more should be done to assure quality of care, quality of life, and the safety in nursing homes. We know there are chronic bad actors. The GAO reported last year, and we just have a new GAO report that we need to go over, just released, which we have not—I have not. So my comments really are directed to the previous one until staff reads it real quick, the new one. Despite positive efforts by the Centers for Medicare and Medicaid Services to improve quality of care, roughly 20 percent of nursing homes nationwide each year are cited for serious deficiencies, and a portion of these homes are chronically deficient.

The GAO also reported shortcomings in the survey and standard enforcement system used to identify problem homes. Government and academic witnesses will testify today about the uneven quality of nursing home inspections and what that means for consumers and regulators.

Witnesses will also testify knowledgably about what more might be done to improve the information supplied to regulators through a survey process and related industry oversight activities. Some developments to improve the quality of information look encouraging. New inspection approaches appear to take a more systematic look at nursing home quality. I look forward to learning how rapidly these can be implemented and how these measures can improve consumer ability to identify quality homes and information and knowledge is power, and I think when people are given a choice, if they have more information, the better. The problem is, in rural America, there are not a lot of choices. Chairman Stupak knows that from his area and I definitely know that in mine.

I also look forward to discussing what Federal officials believe is necessary to strengthen Federal oversight in light of industry trends. There are 100,000 fewer beds today than 10 years ago and nearly 2,000 fewer facilities before bankruptcies, malpractice litigation pressures, and new models of caregiving transformed the industry, according to an HHS study. I have followed the continuing care debate about residential living, then assisted living and then long-term skilled nursing facility and all combined into one, which is, I think, a positive movement in the direction by the industry. Today, half the nursing homes are part of a chain, a rate that has declined from 10 years ago. Over this period there has been corporate restructuring and more focus on regional chains with some new corporate ownership arrangements, and we will hear this morning, it may be difficult to identify how those ultimately accountable for quality-of-care decisions are affecting care. More sunlight on these arrangements may make sense.

The Connecticut attorney general will testify about one troubled chain in Connecticut which continued to operate despite what has been reported as a history of poor care. I look forward to what he found were problems in Connecticut's experience with this chain. Let me note too that Mrs. Aceituno, whose husband suffered while in the care of one of the chain's homes, will tell us her story this morning. Please accept mine and my colleagues' sympathies, and thank you for testifying. Your testimony is very important for us.

I am pleased to learn of the vigorous enforcement HHS Inspector General's Office and the Department of Justice have pursued in recent years—a positive story. In 2007 alone, the HHS IG's Office helped to work 534 cases and the DOJ has already netted $16.6 million in restitution and settlements and false claim act cases that mostly involve nursing homes. We have to ensure we are getting rid of bad actors and encouraging quality improvement, but as we discuss enforcement, we should also focus on what more can be done to identify and address problems before they result in quality care deficiencies.

This brings me to the industry's role in quality safeguards. On that subject, the buck stops with the industry, and so I am eager to learn what steps the industry is taking to set standards, to self-police, to improve quality, and improve quality not just at the margins among minimum standards but at all levels of performance. We need competition for quality. We can drive consumer decisions and improve care for all.

I went over time, Mr. Chairman. Thank you very much, and I yield back.

Mr. STUPAK. I thank the gentleman.

Mr. Chairman Dingell of the full committee for an opening statement, sir.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Mr. Chairman, I thank you. I want to commend you for this hearing, which is a very important one. This is a hearing which is going to build on work done by this committee and this subcommittee over many years.

Today we focus on the quality of nursing homes and how new types of ownership may affect this vital industry. As an original sponsor of the 1987 Nursing Home Reform Act, which originated in this committee as a result of hearings held in this subcommittee, I want this critical law to effectively support and protect those who must live in nursing homes, and again, Mr. Chairman, I commend you for holding this hearing today. There is much that needs to be done here with regard to this industry and with the laws affecting it because it has undergone radical changes since the 1987 law was enacted and there is real need to go into these matters.

Nursing homes are an industry with which new investors and new financing structures unknown to us are beginning to impact significantly on how the healthcare is afforded to our senior citizens and others who are not able to any longer protect themselves without the assistance of this kind of help. This new dynamic raises serious questions about whether profits are being placed be-

fore the needs of nursing home residents, and if so, what needs to be done by this committee and by the Congress since the law has not been reviewed for a number of years.

I look forward to the testimony of Acting Administrator Weems of the Centers for Medicare and Medicaid Services and about what CMS needs in order to better oversee and improve the quality of nursing homes. I will note parenthetically that I am not very well satisfied with the behavior of that agency and with the judgments that they have been making about healthcare in this country. I am hopeful that this hearing will evoke greater cooperation from that agency and perhaps some manifestation of a better philosophy of government inside that agency.

In some ways, the quality of care in our Nation's nursing homes has improved over 20 years but it must be observed there is still a way to go. More than 20 years ago, Congress sought to establish minimum standards for care and quality of life for every nursing home resident. It is disturbing that a subset of today's nursing homes appears to be unable to avoid harm to its residents. That is a curious repetition of events of 20, 30, and 40 years ago when fires, substandard housing conditions, poor treatment of patients in nursing homes, dangers to them and to their health because of improper care and inadequate staffing, were causing significant problems. This hearing is going to receive testimony from Federal, State and municipal authorities about the failure of some nursing homes to meet the basic standards and why they cannot be held accountable.

Clearly, there is much to be said on both sides of this. There are things to be said on the side of the nursing homes if they are not being adequately and properly paid and properly treated by the government. It is also to be said that the government is not engaged in proper supervision or, very frankly, proper reporting to the Congress about the situation that exists in this particular industry.

I want to express my thanks to Connecticut Attorney General Richard Blumenthal for being here. General, thank you for being with us. Mr. Blumenthal will testify about a New England nursing home chain with a troubled history of understaffing, poor care, and unpaid debts. I am sure that is replicated in other places. Also testifying today will be the inspector general for HHS, who will identify ways CMS can more effectively protect nursing home residents. This will be a matter of considerable concern and interest to the Committee.

The day-to-day care for the frail, elderly and disabled is a difficult and, quite frankly, often thankless job. It is complicated by the inadequacy of payment by the Federal Government on these matters. It takes a special person to care for those who cannot care for themselves. No one knows this better than the 500,000 dedicated nursing home workers of the Service Employees International Union, SEIU, and the Nation owes them a great debt for their efforts, and I thank them myself, and for leading the fight for ensuring quality healthcare for every American, they are owed the thanks of all of us.

I also applaud those industry leaders who have advocated higher standards. I particularly want to recognize my friend Bruce

Yarwood, president of the American Health Care Association, AHCA, as one of those leaders who has set the bar high through the "Advancing Excellence" campaign.

Finally, I welcome Mrs. Aceituno, who will share the story about her husband's experience in a facility that she trusted would keep him safe. Mr. Aceituno became paralyzed while a resident of this facility and is now confined to a wheelchair. This is of course not easy for Mrs. Aceituno, but we are grateful to her for putting a human face on what can happen when nursing home owners place profits before people in their care.

Mr. Chairman, the proceeding of this committee is a very important one. The facts to be gleaned are extremely important. The information is going to enable us to look to see what action this committee and this Congress should take with regard to protecting not only the public interest but the inmates of the nursing homes. It also will help us understand what changes in the laws are needed, and I commend you for your leadership in this.

Thank you, Mr. Chairman.

Mr. STUPAK. Thank you, Mr. Dingell.

Ms. Blackburn for an opening statement, please.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Ms. BLACKBURN. Thank you, Mr. Chairman, and you all were talking about 1977 being the last benchmark. The last time we had a hearing, and I have a benchmark for that year of my own, my first child was born in 1977, and on Monday she gave birth to my first grandchild. So I hope that we have good nursing home care for people like me. But I do thank you for holding the hearing and for taking the time to review long-term quality care in our Nation's nursing facilities.

Whenever I talk about healthcare with my constituents, my top concern is preserving and enhancing access to quality care and doing it in an affordable manner. That is what our constituents want. And as our Nation's population ages, more Americans are looking at options for elder care, and since my days in the Tennessee State Senate, I have had a record of supporting long-term care options for seniors, whether it is found in nursing homes, long-term care hospitals, or additional options that they want to have to meet their needs.

I would also like to say, my district is home to Advocate, a provider of long-term care services for patients in nursing homes in eight States, primarily in the southeast, and I know this is a highly regulated industry and Advocate and many of their competitors have shown a commitment to transparency, and we appreciate that because we have learned a few things and I think one of those, Mr. Chairman, is that it is important that reported quality-related data be meaningful and useful, not only to consumers but to us as lawmakers and to care providers. I am looking forward to testimony from today's witnesses regarding opportunities to revise and improve quality of care, quality of life, and staffing data collection when treating the elderly. Instead of placing additional regulation on the industry, it is prudent to improve the quality and nature of

information currently reported to the government and, I think also, Mr. Chairman, for us to establish a matrix whereby evaluated data provides insight into the outcomes that are provided for care. Bad actors are found in every single industry that there is, and I caution against holding the good actors responsible for poor performers. In addition, I am concerned about the public perception of some of the hearings that we have and how they can create public fear. I do appreciate an open and honest debate and warn against opening the doors to trial lawyers who may want to police the long-term care industry.

As a baby boomer, as I said earlier, and now a grandmamma, I recognize that the Nation's healthcare sector is evolving to meet the needs of an aging population. Everyone wants assurance that the elder care industry works to improve the quality of long-term care for the benefit of every American retiree today and in the years and decades ahead.

I yield back.

Mr. STUPAK. I thank the gentlewoman.

The audience should note that there is another hearing going on upstairs in the Health Subcommittee so members will be bouncing back and forth throughout this hearing.

Mr. Green for an opening statement, please.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, and thank you for holding this hearing, and like a lot of members, I am also on the Health Subcommittee and I am going to go up there in a few minutes, but I want to thank our witnesses for being here and thank you for calling this hearing.

Like my colleague from Tennessee, for many years I was a State legislator in Texas, and nursing home regulation was something we dealt with every session, but since 1987, a more aggressive effort. It is interesting, though. I always thought it was regulated on the State level but since most of the Medicaid money is from the Federal Government, 60 percent typically, it was often difficult, because I know in Texas our Medicaid program is not as rich as some other States, but it is such a big part of our Medicaid dollar in Texas.

The decision to take a loved one to a nursing home is a difficult decision, and I have not known anyone who would not rather have their family member remain independent or at home with them and not make that decision. In fact, I want to welcome Mrs. Aceituno because a number of years ago my wife and I had to make that same decision. Her mother was diagnosed in 1995 with Alzheimer's, and we didn't go to a nursing home but we kept her independent as long as we could but then to an Alzheimer's center, which is like a nursing home but set up for Alzheimer's patients. Ultimately she passed away in a nursing home but it was really hospice care because it used to be hospice was separate but now they are also part of nursing home facilities in Christmas of 2006, and a lot of people think elected officials, we don't experience the same things everybody does, but we do. Our family went through that illness for 10 years, and I know members of Congress who are

on our full committee who are going through it right now with their families. So it is a difficult decision, and I am glad you are willing to come and testify.

I have to admit, we had problems in Texas and Louisiana with hurricanes 3 years ago, and my mother-in-law was under hospice care, and when Rita was coming into, we thought Houston, but it ended up going to Beaumont just to the east, and we had had a terrible experience in Louisiana with nursing home patients not having evacuation procedures, and our office actually checked every one of ours, and while everybody was stuck on the freeway leaving Houston, I went to the one where my mother-in-law was at and was really proud that they had cots on the floor for the staff, they had brought in staff to make sure they would be there. We only lived 2 miles from them so I was going to go over there and be there anyway, but in that case, and it was a chain nursing home, was very well prepared to deal with the patients at that facility, and again she was part of the hospice facility on that.

When we do have to make those decisions as families, people turn to nursing homes to give their loved ones the type of care they cannot provide. They entrust those nursing homes with their family members, and again, the squeaky wheel gets the oil whether you are here in government or in the private sector, and if you are there all the time, you keep on it, you will actually see because oftentimes the understaffing, I know the requirements by statute and by regulation but oftentimes it is difficult so families have to stay involved. But in the past, nursing homes were mainly mom-and-pop institutions and we have those in my district too, but times have changed and now we have the larger chain nursing homes in multiple States, and this corporate structure of nursing homes is sometimes a tangled web of finances that at times requires a forensic accountant to figure out who actually owns a specific nursing home. In instances where complaints have been made against the home where tragedies have resulted from abuse or mistreatment, it is often difficult for CMS to deal with this new system of nursing homes to levy fines or enforcement penalties, and that is what this hearing is about today.

Mr. Chairman, I would like the remainder of my statement to be placed in the record so we can go forward with the hearing, but I appreciate your calling this hearing.

[The prepared statement of Mr. Green follows:]

STATEMENT OF HON. GENE GREEN

Mr. Chairman, I want to thank you for holding this hearing today on nursing home safeguards.

The decision to take a loved one to a nursing home facility is often a difficult decision. I don't know anyone who wouldn't rather have their family member remain independent or at home with them.

Sometimes the circumstances do not allow for families to have their loved ones stay with them. Oftentimes, individuals need a quality of care and around the clock monitoring that families cannot provide.

When this happens, most people turn to nursing homes to give their loved ones the type of care they cannot provide. They entrust nursing homes with their family members, hoping they will receive quality care.

In the past many nursing homes were mom and pop institutions, but times have changed and now most nursing homes are part of a larger chain of nursing homes, sometimes throughout multiple states.

Along with this new corporate structure of nursing homes has come a tangled web of finances that at times has required a forensic accountant to figure out just who owns a specific nursing home.

In instances where complaints have been made against the home or tragedies have resulted from abuse or mistreatment, it is often difficult for CMS to deal with this new system of nursing homes to levy fines or enforce penalties.

We have found that CMS sometimes does not know who owns a nursing home or even if one nursing home is part of a larger chain. Right now, CMS has a survey and enforcement system that was never designed to identify chain-wide or systematic problems.

We cannot allow this to happen, and clearly a new enforcement system must be put into place that will give greater transparency to the system and we need a system that will allow CMS to know who the facility operator is.

We need to know when we put our loved ones into a nursing home facility they will be safe and well taken care of.

I am hopeful this hearing today will shed some light on the problems with nursing home safeguards nationwide and action congress can take to help give families a greater piece of mind and patients the protections they deserve.

Thank you Mr. Chairman, I yield back my time.

Mr. STUPAK. I thank the gentleman and look forward to his participation throughout the morning.

Mr. Burgess for an opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman, and I too appreciate you holding this hearing. I note the chairman of the full committee said he was looking forward to hearing the testimony of Administrator Kerry Weems. I am as well. Unfortunately, we will have to wait until the end of this hearing to hear that testimony, and once again, we are in the awkward position of tying up the head of a large Federal agency for the better part of a day when we know they have other important things on their plate. You know this is an issue that bothers me and I do wish the committee would approach this with a little more sensitivity.

Representative Blackburn talked about long-term care insurance, and I know that is not the purpose of this hearing today but I do also want to mention just a little bit about long-term care insurance. I was at the Alzheimer's Association fundraiser last night, the banquet that they have, and it really is apparent to me that we are not as a body talking about long-term care insurance and the availability of long-term care insurance nearly enough with the American people that it even pops up on their radar screen. When I turned 50 years old, which was unfortunately some time ago, my mother, in fact, one of the last pieces of advice my mother gave to me was to consider buying long-term care insurance because she told me if you don't buy it when you are 50, you won't be able to afford it when you are 75 or 80, and truly that was good advice and I do want us to use our opportunities with the ability to inform the American people that the availability and the cost of long-term care insurance in midlife is an affordable option that people ought to consider. Yes, the Medicaid program will pick up the cost of your nursing home expense but at least in my home State of Texas, they are only obligated to place you within 500 miles of your home. That means for someone living in Louisville, Texas, as I do, they might be placed in a nursing home in Paris, Texas, and if you think—

Representative Blackburn is gone, but if you think it is hard to get your grandkids to visit you when you only live a few miles away, try living 500 miles away. So it is something that is important. I do want this committee to focus on that.

There are so many issues involved in the topic at hand today. I am glad to see we are focusing on this issue. I do hope that the panel before us today will focus specifically on some issues related to transparency and the type of transparency that is needed in the industry. Perhaps the best information we can give consumers is information about not just the cost of the stay in the nursing home, and I would prefer that we call them residents of the nursing home rather than inmates, but cost as well as things like infection rates, things like the availability of occupational and physical therapy. The problem is, I am afraid this hearing is going to get bogged down in trying to figure out who owns what and who has done what to whom.

I have always been a strong advocate of transparency in the medical and nursing community, and recently introduced a bill about greater transparency in health information technology in the health industry. H.R. 5885, for anyone keeping score at home, would allow hospitals and physicians' offices to integrate information technology in a much more seamless manner than they are able to do currently, and this issue seems on point for this hearing today because it appears that a major problem of monitoring and enforcement and regulation of nursing homes is the lack of integrated information being supplied to people like Administrator Weems at the Center for Medicare and Medicaid Services.

I still wonder if the larger problem lies not with a general lack of transparency but with the lack of consistent and uniform enforcement. So often we are seeing good nursing homes found deficient and given fines because of a regulator who was sent to their facility perhaps in a somewhat overzealous manner. Meanwhile, nursing homes that have a poor indicator of quality are given a seal of approval because the regulator sent to check up on them employed a much more laid-back approach. I am interested in learning about the effectiveness of the Quality Indicator Survey pilot program and how it can effectively work on a nationwide scale.

And finally, I can't help but notice the recent New York Times article that focused on this topic and noted the frustration of our friends on the trial bar, personal injury lawyers who are having a hard time figuring out whom to sue, and while I feel their pain, one of the problems that we are facing today, we are critical of large chains that have acquired a larger and larger ownership share of nursing homes but we have sued and regulated and underfunded the smaller owner of the nursing home just completely out of existence in the past 10 years, and while some of that fault perhaps lies at the State level, a good deal of that blame lies here on the doorstep of the United States House of Representatives, so I do hope that rather just simply focusing on whom to blame in this discussion today, we might be able to focus on a few solutions because after all, that is what the American people sent us here for.

I will yield back the balance of my time, Mr. Chairman.

Mr. STUPAK. I thank the gentleman.

I want to compliment Administrator Weems for being here and sitting through this. He was given the option, if he so chose, to have a staff person sit and take notes and come down when his panel appeared. To his credit, he stayed, and I appreciate him being here, especially since it has been 31 years since Congress has looked at this issue. I think there are things we can all learn from this hearing today. So I welcome his participation and his willingness to be with us at this hearing.

Next I would turn to Mr. Barton for an opening statement, sir.

Mr. BARTON. Mr. Chairman, I will put my opening statement formally in the record. I do want to say, though I think this is a very good hearing. We haven't done oversight on the nursing home industry in a number of years and so I think you and Mr. Dingell are to be commended for doing this, and we will work with you in a bipartisan basis to uncover the facts, and if actions are necessary after we uncover the facts, to implement those actions, so we appreciate the hearing.

[The prepared statement of Mr. Barton follows:]

STATEMENT OF HON. JOE BARTON

Chairman Stupak and Ranking Member Shimkus, thank you for convening this important hearing. Good nursing home care is very important to the three million Americans who are receiving care this year in the 16,000 federally certified nursing homes.

One measure of a society is how it cares for its elderly. Some of us here today aren't too far from finding out directly, and many of us have aging parents or grandparents who already know. Over the past few decades, Americans have relied more and more upon skilled nursing facilities to care for those we love, usually in the most fragile and vulnerable moments of their lives. Nearly two-thirds of all nursing home care is paid by Federal, State and local taxpayers, and it cost them more than $78 billion in 2006.

The challenges to maintaining quality care are great. And we must be vigilant to find ways to improve the safeguards we have established through legislation like the Nursing Home Reform Act that was part of what is known as OBRA 87. So this subcommittee's oversight work is vital to fulfilling our congressional responsibility to protect the interests and lives of our elderly.

The nursing home industry is complex and it changes rapidly. This industry has expanded to include national and regional chains, small groups, non-profits, and for-profits. There are even some mom-and-pop nursing homes. And there are facilities that specialize in certain types of care, such as rehab or helping people with Alzheimer's disease.

The industry has long suffered a mixed reputation. Most folks in the business are decent people who mean well and work hard every day to provide care to our loved ones, but some of the unhappy reputation is deserved. According to the GAO and to the inspector general of HHS, nursing home operations also give rise to bad players and scofflaws.

Rules need to be vigorously enforced to rid the industry of its scofflaws and to deter anyone who would skimp on care in order to swell an illegitimate profit. A bright dose of sunshine into nursing home practices may be needed to expose offensive acts and discourage bad behavior. We will hear about transparency today. That is a good thing and I think it should be encouraged. More information helps families make good choices and helps regulators identify bad operators.

But as we talk about safeguards, we should remember the law of unintended consequences so we do not hinder more than we help. I think we have to be wary of one-size-fits all solutions and the kind of rigid, made-in-Washington policies that never seem to work.

It's also important to recognize that this is not your grandfather's nursing home industry. In recent years, some publicly owned chains have gone private, and others have been transformed by complex new ownership structures. I have questions about some of these operating arrangements, especially where the property is owned by one firm and the care is delivered by another.

There is not clear evidence yet that these changes are bad or good. Some may actually provide more focused resources that result in improved care.

I believe that we need a strong and flexible regulatory system to ensure folks are meeting applicable standards, and that encourages accountability and quality innovation.

I look forward to hearing from our witnesses today about systems for addressing quality and anticipating problems. These are areas where industry really can improve, and I hope we learn that they are ready to do so.

# # #

Mr. STUPAK. Thank you, Mr. Chairman.

Ms. Schakowsky was here but she must have stepped out. She probably ran upstairs, because I know she is on the Health Subcommittee also.

So let us conclude the opening statements by members and let us turn to our first panel of witnesses. On our first panel, we have Mr. Lewis Morris, the Chief Counsel to the Inspector General for the U.S. Department of Health and Human Services; the Hon. Richard Blumenthal, Attorney General for the State of Connecticut; Luis Navas-Migueloa, long-term care ombudsman for the city of Baltimore; and Ms. Susana Aceituno, the wife of the Connecticut man who broke his back and was paralyzed at the nursing home. So we welcome all of our witnesses. Thank you for being here.

It is the policy of this subcommittee to take all testimony under oath. Please be advised that witnesses have the right under the Rules of the House to be advised by counsel during their testimony. Do any of our four witnesses wish to be advised by counsel during their testimony? The indication is no. Therefore, I am going to ask to please rise, raise your right hand, and to take the oath.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect that the witnesses replied in the affirmative. You are all under oath.

I will begin opening statements. I am going to ask Mr. Morris to begin with the opening statements. We will go right down the line, 5-minute opening statements. If you have a longer statement, we will insert it in the record. Mr. Morris, if you would begin, please.

STATEMENT OF LEWIS MORRIS, CHIEF COUNSEL TO THE INSPECTOR GENERAL, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MORRIS. Good morning, Chairman Stupak and distinguished members of the Committee. My name is Lewis Morris. I am Chief Counsel in the Office of the Inspector General at the Department of Health and Human Services.

As a result of congressional action and efforts by CMS and the nursing home industry, important steps have been taken to improve residents' health and quality of life. Unfortunately, not all nursing homes consistently provide the level and amount of care that the residents require. In 2006, almost one in five nursing homes was cited for deficiencies that caused actual harm or placed residents in immediate jeopardy.

OIG affirmatively addresses nursing home vulnerabilities in three ways: oversight, enforcement, and guidance. First, in our oversight role, OIG has conducted approximately 90 evaluations of

the nursing home program since major nursing home reforms of 2 decades ago. One of our recommendations was the development of a national abuse registry for long-term care employees. We have found that without accurate and accessible background information, nursing homes may hire individuals who could place residents at considerable risk.

In our enforcement role, OIG has investigated cases of egregiously substandard care in nursing homes and pursued criminal, civil, and administrative remedies against those who harm our beneficiaries. We have collaborated extensively with the Department of Justice and State Medicaid fraud control units to successfully prosecute nursing homes and caregivers for failing to provide basic levels of care including cases of residents suffering from preventable pressure sores, untreated broken bones, drug overdoses, and death. OIG has excluded from participation in Federal healthcare programs caregivers who have abused or neglected residents as well as nursing home administrators and operators for systemic failures. In these cases, we may not exclude the facilities providing bad care if we believe it is in the best interest of the residents. As an alternative, we negotiate corporate integrity agreements which establish comprehensive compliance programs and require appointment of an independent quality monitor. The monitor has extensive access to all aspects of the organization and makes recommendations to address underlying deficiencies. These compliance programs have been instrumental in improving the quality of care.

As a third initiative, we promote compliance with our program requirements and greater awareness of quality-of-care issues. For example, we recently published a draft supplemental guidance that discusses the fraud and abuse risks that nursing homes should address when implementing a compliance program. OIG also is working to increase awareness by stakeholders of the importance of delivering quality of care. For example, we recently co-authored a Healthcare Board of Directors Resources Guide. Last year we met with nursing home representatives from across the country to explore how to better inform their boards about the quality of care provided in their facilities. Consumers should also have reliable, user-friendly data on nursing home quality to make informed choices for family members.

OIG makes three recommendations we believe will contribute to improving the quality of care that residents receive in nursing homes. First, create a nationwide centralized database to improve screening of nursing home staff. That database could merge the OIG's exclusion database, State nurse aide registries and disciplinary actions by licensure boards. We believe such a database would reduce the risk that potentially abusive caregivers will be employed to care for this vulnerable population.

Second, direct CMS to create demonstration projects to establish mandatory compliance programs for nursing homes. Effective compliance programs can help reduce fraud and abuse, enhance operational functions, and improve the quality of healthcare services.

And third, enhance the quality of data made available to the nursing home industry and to the public. CMS's Nursing Home Compare Web site offers consumers and the nursing home industry

a good base of information on the quality of nursing homes. However, the Web site can be improved by adding data that provides a clearer and more comprehensive picture of the specific facility as well as the performance of the nursing home chain.

Thank you for the opportunity to testify today, and that concludes my remarks. I look forward to your questions.

[The prepared statement of Mr. Morris follows:]

Testimony before the

Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives

"In the Hands of Strangers: Are Nursing Home Safeguards Working?"

Testimony of

Lewis Morris
Chief Counsel to the Inspector General

Office of Inspector General
Department of Health and Human Services

May 15, 2008
10:00 a.m.
2123 Rayburn House Office Building

Daniel R. Levinson,
Inspector General
Department of Health and Human Services

Testimony of:
Lewis Morris
Chief Counsel to the Inspector General
U.S. Department of Health and Human Services

Good morning, Chairman Stupak and distinguished members of the Committee. I am Lewis Morris, Chief Counsel to the Inspector General of the Department of Health and Human Services. I appreciate the opportunity to appear before you today to discuss our work related to nursing home quality issues. The Office of Inspector General (OIG) shares your commitment to ensuring the well-being of nursing home residents and the proper oversight of programs designed to serve this vulnerable population. I look forward to discussing with you today some of the ways OIG seeks to fulfill these goals.

A large portion of OIG's work in the area of nursing homes is aimed at identifying and recommending methods to reduce inappropriate payments, close programmatic loopholes, and evaluate payment and pricing methods to ensure that Medicare and Medicaid receive value for program expenditures. Ensuring that nursing homes receive appropriate payment for quality services not only promotes the interest of taxpayers, but also protects nursing home residents. Fraudulently billed services drain the Medicare and Medicaid program funds, as well as residents' personal savings in the form of excessive copayments and deductibles.

In addition to promoting financial integrity, Inspector General Daniel Levinson has made improving the quality of care a top priority for OIG, because behind every claim for reimbursement is a program beneficiary. In particular, OIG has long been concerned with the quality of care rendered in nursing facilities. OIG's efforts to improve quality of care in nursing homes involve three strategies: (1) the evaluation of the systems used to oversee quality of care, (2) the investigation and prosecution of cases of egregiously substandard care, and (3) the provision of guidance to the long term care industry in order to encourage program compliance and high quality care.

In my testimony today, I will describe the studies, enforcement actions, initiatives, and Government-industry collaboration that OIG has undertaken to identify ways to improve the quality of care provided to our beneficiaries. I will conclude my testimony by offering several recommendations that we believe will advance this objective.

OIG's Assessment of the Programs and Systems for Ensuring Quality of Care

Nursing homes have been a particular focus for OIG over the past decade because of the increasing number of beneficiaries living in long-term care facilities and the unique vulnerabilities associated with this population. Nursing home residents not only rely on facilities to provide them with proper medical care, but also depend on them to provide the basic life necessities, such as proper nutrition, safe living environments, and any assistance with their

activities of daily living. Unfortunately not all nursing homes consistently provide the level and amount of care, support, and assistance necessary to adequately promote and sustain their residents' health and quality of life.

The oversight and regulation of nursing homes that participate in the Medicare and Medicaid programs are primarily the responsibility of the Centers for Medicare & Medicaid Services (CMS) and State agencies through their survey and certification efforts. However, OIG work has determined that CMS and State mechanisms to identify and correct quality-of-care problems in nursing homes do not always function as designed. In addition, OIG has identified shortcomings in the methods used by nursing homes to screen prospective employees to ensure that potentially abusive care workers are not hired. Such shortcomings can result in quality-of-care problems not being detected timely, the continued Government payment to poorly performing nursing homes, and the hiring of staff with a history of mistreating residents.

Effectiveness of CMS and State Oversight of Nursing Homes

CMS establishes quality-of-care standards and conditions of participation for the Medicare and Medicaid programs. Through a system of periodic facility inspections and individual complaint investigations, CMS and the State agencies assess nursing home performance and determine whether to certify, or recertify, facilities for participation in Medicare and Medicaid. As part of this process, surveyors identify whether facilities are falling short in certain quality-of-care measures, such as providing proper treatment to prevent or treat pressure sores, appropriate treatment for mental or psychosocial functioning, adequate supervision and/or devices to prevent accidents, proper nutrition and fluid intake, and appropriate levels and types of medication. Nursing facility standard surveys are required by statute to be conducted at least every 15 months, and the statewide average interval between surveys of facilities cannot exceed 12 months.

When facilities are found to be out of compliance for designated time periods or have deficiencies that put residents in immediate jeopardy, States are required to refer the case to CMS for enforcement action. In particularly egregious cases of noncompliance, enforcement actions are mandatory. Such actions can include corrective action plans, civil monetary penalties (CMP), required changes in management, denial of payment for new admissions, or termination of a facility's Medicare and/or Medicaid contract. OIG reviews of the use of these processes indicate that CMS and States do not always effectively or fully use existing tools and authorities to identify, monitor, or bring back into compliance nursing homes that do not meet required quality standards.

For instance, both OIG and Government Accountability Office (GAO) work identified inaccurate and inconsistent deficiency citations as well as delayed responses to complaints. To illustrate, in a March 2003 report, OIG reviewed trends in survey and certification deficiencies, as well as the effectiveness and consistency of the survey and certification process. This work identified inconsistencies in the manner in which deficiencies were cited by the various State survey agencies. These inconsistencies resulted from variations in survey focus, unclear guidelines, lack of a common review process for draft survey reports, and high turnover of surveyor staff. In a 2007 report, GAO found that State surveys sometimes understate the extent of serious care

problems that cause actual harm or place residents in immediate jeopardy, that there continued to be significant variation across States in their citation of these types of deficiencies, and that there continue to be weaknesses in Federal oversight of State survey activities.

OIG has also assessed the implementation of States' oversight of abuse- and neglect-reporting requirements. The Omnibus Budget Reconciliation Act of 1987 requires States to provide timely reviews of complaints and to promptly investigate allegations of neglect, abuse, and misappropriation of resident property. In a July 2006 evaluation, OIG found that State agencies did not investigate some of the most serious nursing home complaints within the required timeframe and that CMS's oversight of nursing home complaint investigations is limited. CMS has since updated the State Performance Standard, which it uses to hold State agencies accountable for the timeliness of their complaint investigations, to make the timeframe consistent with the 10-day requirement in its "State Operations Manual."

When facilities are found to be out of compliance with quality standards, CMPs are an important element of an effective enforcement strategy, especially in cases when nursing homes are out of compliance for designated time periods or have deficiencies that put residents in immediate jeopardy. Unfortunately, this tool has not been used to its full potential. For example, in an April 2005 report, OIG found that although $81.7 million in CMPs were imposed during 2000 and 2001, CMS had collected only $34.6 million (42 percent) by the end of 2002. The unpaid portion included reductions resulting from compromises with nursing homes waiving their right to appeal, settlements and reductions resulting from appeals, payment delays caused by appeals or bankruptcy proceedings, and nonpayment of collectible CMPs. We found that CMS did not utilize the full dollar range allowed for CMPs and that impositions were frequently at the lower end of the allowed ranges. Low imposition rates and slow and/or difficult collection efforts may minimize the coercive remedial effect that CMPs ultimately have on noncompliant facilities.

Denying payment for new admissions is another powerful tool that CMS can use to protect beneficiaries while bringing nursing homes into compliance. CMS must impose this sanction, or a more severe penalty, on homes that remain out of compliance with Federal standards for more than 3 months or when three consecutive surveys detect substandard quality of care. When properly implemented, the sanction works to divert new patients to more suitable facilities until such time as the deficient nursing home improves. OIG recently completed a study that found processing errors in nearly three quarters of the instances in which CMS attempted to impose the sanction on substandard nursing facilities. In rooting out the cause of these errors, we identified numerous communication breakdowns between CMS and the contractors that process Medicare claims. We proposed several solutions to improve communication and accountability, and CMS indicated that it will implement changes to ensure more effective use of this remedy.

In the most egregious cases, termination of the nursing home may be the only effective means of protecting nursing home residents from danger. When a facility either fails to correct an immediate jeopardy situation, an instance involving actual or potential for death or serious injury, or fails for two successive surveys to correct deficiencies that involve any level of actual harm to residents, termination from the Federal heath care programs is mandatory. In a report issued in May 2006, OIG found that for the majority of cases requiring mandatory termination of

nursing facilities, CMS failed to apply this sanction because of both late case referrals by States and CMS staff's reluctance to impose this severe remedy. Significantly, OIG found that all of the facilities that failed to implement the termination remedy in a timely manner were subsequently cited for noncompliance that was serious enough to require referral to CMS for enforcement action. Ten of the 29 facilities that CMS failed to terminate were cited with immediate jeopardy deficiencies and 1 facility was cited with an immediate jeopardy deficiency four times in consecutive years. Fourteen of the 29 facilities reviewed had deficiencies that were sufficiently serious to warrant referral to CMS for enforcement in three or more subsequent surveys. To address these problems, CMS has committed to taking a number of actions, including implementing both case- and incident-tracking systems, which should help to ensure that enforcement actions are properly taken when warranted and implemented more timely.

Moving forward, OIG is continuing its oversight reviews of issues such as the use of antipsychotic drugs in nursing homes, the appropriateness of psychotherapy services provided to Medicare beneficiaries in nursing homes, the impact of transitioning into Part D on nursing home residents' ability to obtain needed drugs, the nature and extent of survey and certification deficiencies in nursing homes and patterns of repeated noncompliance with Federal quality standards, and whether States are correctly applying civil monetary funds to programs that protect the health or property of nursing home residents.

Nursing Home Screening of Employees

Residents of nursing homes have a right to live in safe and secure environments, free from abuse at the hands of their caregivers. OIG has found, however, that States and nursing facilities currently depend on a patchwork of data sources to identify persons posing possible threats of elder abuse in nursing homes and to minimize and prevent such abuse.

For instance, nursing homes should screen their staff and prospective staff against the OIG's List of Excluded Individuals and Entities (LEIE). Under a congressional mandate (sections 1128 and 1156 of the Social Security Act), OIG established a program to exclude individuals and entities affected by these authorities. Once a person is excluded, Federal health care programs will not pay for items or services furnished by that person. Screening staff against the LEIE helps ensure that a nursing home does not employ an excluded person and that it does not bill Federal health care programs for any excluded person's work.

Exclusions related to quality of care arise in the following situations; therefore, checking against the LEIE will help nursing facilities to ensure that the following types of individuals are not employed:

- OIG must exclude any person convicted of an offense related to the abuse or neglect of a patient in connection with the delivery of health care;
- OIG may exclude any person whose license to practice health care has been revoked or suspended for reasons bearing on the person's professional competence or professional performance;

- OIG may exclude any person who has furnished items or services to patients: (1) that are substantially in excess of the needs of such patients or (2) that fail to meet professionally recognized standards of care; and

- OIG may exclude anyone who has caused the submission of false or fraudulent claims to a Federal health care program.[1]

In addition to using the LEIE, nursing facilities should screen prospective nurse aides and other nonlicensed direct care staff through the use of the State nurse aide registries. Federal regulations prohibit facilities from employing individuals who have been found guilty by a court of law or who have had findings entered into the registry for abuse, neglect, or mistreatment of residents or misappropriation of their property. Each State is required to establish and maintain a registry of nurse aides, which includes information on any finding by the State certification agency of abuse, neglect, or misappropriation of property belonging to the elderly.

In a July 2005 report, OIG found that although most facilities check their State nurse aide registries prior to employing an individual, they do not routinely check registries in other States, thereby potentially jeopardizing the safety of their residents. Additionally, while most States require criminal background checks, the scope of these checks varies widely. Although some of the nursing facilities in our sample conducted more comprehensive checks than required by their State laws, about half of the background checks performed were limited in scope, e.g., limited to one State. Additionally, in a February 2005 report, OIG examined the accuracy of nurse aide registries maintained by States and found that some States failed to adequately update registries with information on substantiated adverse findings against nurse aides. In fact, some individuals with criminal records in one State were certified in other States and therefore still able to have access to residents.

Without accurate nurse aide registry information, nursing homes may inadvertently hire aides who have committed criminal offenses, such as abuse, neglect, and theft, which place residents at considerable risk. To reduce the potential risk to residents, OIG recommended that CMS seek legislative authority to create a national nurse aide registry and to consider developing a Federal requirement for comprehensive criminal background checks.

Pursuant to section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS implemented a seven-State criminal background check pilot program. The purpose of this pilot is to determine effective and efficient methods for conducting State and national background checks and searches of relevant registries for screening prospective direct care employees in nursing homes and other long-term care facilities. Funding for the program ended in September 2007 and an evaluation of the pilot is expected to be completed in the near future.

[1] This provision parallels the False Claims Act and is implicated in any case in which the Government is asserting a failure-of-care theory in a civil case.

OIG Quality-of-Care Investigations and Enforcement

As previously described, the survey and certification process provides several mechanisms for the identification of quality-of-care deficiencies and the enforcement of nursing home standards through the use of remedies such as corrective action plans, CMPs, suspension of intake of new Medicare and Medicaid patients, and required changes in management. However, in some cases, the quality of care is so deplorable that these types of remedies are not sufficient. In such instances, the Department of Justice (DOJ), OIG, State Medicaid Fraud Control Units (MFCU), and other law enforcement partners have used the criminal and civil fraud statutes to pursue cases of substandard care. Under the False Claims Act, the Government is authorized to collect substantial penalties against anyone who has knowingly caused the submission of false or fraudulent claims to the Federal Government.

The predominant criminal and civil fraud theories—medically unnecessary services and "failure of care"—rely on the submission of a claim for reimbursement to the Government to establish jurisdiction over the provider. The first theory is based on the fact that Medicare and Medicaid cover only costs that are reasonable and necessary for the diagnosis or treatment of illness or injury. When medically unnecessary services are provided and billed to Federal health care programs, the claims are fraudulent, the patient is unnecessarily exposed to risks of a medical procedure, and the Federal health care programs incur needless costs. The second theory of liability involves the provision of care that is so deficient that it amounts to no care at all. This theory derives from the concept commonly applied in the financial fraud context, which subjects providers to liability for billing Government programs for services that were not actually rendered as claimed. The Government has pursued this civil cause of action only in cases that involve systemic and widespread problems of quality or significant harm to patients.

Prosecuting Providers of Substandard Care

Pursuant to the Deficit Reduction Act of 2005, OIG has heightened its collaborative efforts with State and local law enforcement entities. For example, in 2007, OIG worked 534 cases jointly with State MFCUs. We also continue our close work with DOJ pursuing failure-of-care cases under the Federal False Claims Act. For example, during 2007, we settled cases with two nursing home chains resulting in quality-of-care CIAs covering all of the facilities within those chains. Both cases involved OIG attorneys and special agents, Assistant United States Attorneys, trial attorneys from DOJ, and attorneys and investigators from State MFCUs. This level of coordination has become the standard for quality-of-care work.

The 2007 settlement with Ciena Healthcare Management, Inc., a provider of management services to 32 skilled nursing facilities located throughout the State of Michigan, provides a recent example of a failure-of-care case. In this case, the United States and the State of Michigan alleged that the defendants violated the False Claims Act by submitting claims to Medicare and Medicaid for services at four Ciena facilities that failed to meet the following resident needs: (1) resident nutrition and hydration, (2) assessment and evaluation, (3) care planning and nursing interventions, (4) medication management, (5) fall prevention and management, and (6) pressure ulcer care. Under the settlement agreement, the defendants agreed

to pay the United States $1.25 million and enter into a chain-wide quality-of-care Corporate Integrity Agreement (CIA) that covers all 32 Ciena facilities.[2]

In another example, in 2005, the Government settled a False Claims Act case with Life Care of Lawrenceville, a Georgia nursing home, for $2.5 million. Many of the problems at Life Care of Lawrenceville were related to chronic understaffing. Among the examples of poor care alleged by the Government, a resident on coumadin, a blood-thinning medication, died of toxic poisoning because the facility staff failed to check his blood-clotting times. Another resident allegedly fell four times during her 4-month stay and fractured and refractured her hip. Still another resident allegedly developed maggots in her mouth and died of larvae infestation because the facility staff failed to provide basic oral hygiene care. Life Care and OIG entered into a quality-of-care CIA for the Lawrenceville facility.

To further illustrate, Federal prosecutors in Missouri charged American Healthcare Management (AHM), a long-term care facility management company, its Chief Executive Officer, and three nursing homes with criminal conspiracy and health care fraud based on their imposition of budgetary constraints that prevented the facilities from providing adequate care to residents. The investigation found that numerous residents suffered from dehydration and malnutrition, went for extended periods of time without cleaning or bathing, and contracted preventable pressure sores. In 2005, the corporate defendants were convicted and fined, entered into a False Claims Act settlement of $1.25 million, and agreed to be excluded. The primary owner was convicted of a false statement misdemeanor offense, was sentenced to 2 months incarceration, and agreed to be excluded for 20 years. Finally, in February 2007, AHM's former CEO was sentenced to 18 months of incarceration and fined $29,000.

In a final example, Ronald Reagan Atrium Nursing Home, a Pennsylvania nursing home, and its owner/operator were convicted in 2007 of health care fraud and false statements after a 6-week trial in which evidence showed that employees were directed to falsify medical records to conceal the nursing home's deficiencies. As a result of the scheme, the nursing home billed Medicare and Medicaid for services provided to residents, most of whom suffered from Alzheimer's disease, that either were not provided or were substandard. The nursing home, which is now closed, was ordered to pay a $490,000 fine. The owner/operator was sentenced to 5 years in prison and ordered to pay a $50,000 fine. The investigation also revealed, that although the nursing home claimed that it did not have the ability to pay food and pharmaceutical vendors, it donated $1 million to another nonprofit company, which, in turn, paid the owner/operator an exorbitant salary.

Excluding Caregivers and Owners

Exclusion actions fall under two broad categories: (1) derivative (based on an action by another Government agency or tribunal) and (2) affirmative (initiated independently by OIG). OIG uses these exclusion authorities to build upon and supplement enforcement actions taken by States, CMS, and DOJ. To provide protection to Federal health care program beneficiaries, OIG imposes derivative exclusions of persons who have been convicted of patient abuse or neglect or

[2] Quality-of-care CIAs are described in further detail on page 11 of this statement.

who have lost medical, nursing, or other health care licenses for reasons related to abuse or neglect of patients or professional competence. In fiscal year 2006, OIG excluded 295 persons based on convictions of patient abuse or neglect and 1,867 persons based on revocation or loss of health care licenses.

In addition to imposing these large numbers of derivative exclusions, OIG initiates affirmative exclusions to address serious quality-of-care problems that have not been addressed through other enforcement actions. As part of this affirmative strategy, we can exclude direct caregivers who pose a risk to patients, the owners and managers who are responsible for allowing the abuse of patients or provision of substandard care, as well as entities that have demonstrable, systemic poor quality of care. For example, OIG excluded a nursing home owner for causing the provision of substandard care in his facilities as a result of providing insufficient staffing and financial support. Because the owner was not a licensed health care professional (or nursing home administrator), the exclusion was the most effective way to bar him from involvement in Federal health care programs.

Establishing Accountability

In investigating and resolving cases such as those described above, law enforcement often struggles to determine who in the organization's management should be held responsible for the egregiously poor care. Federal and State law enforcement have therefore resorted to resource intensive and time-consuming investigative and auditing techniques to determine the roles and responsibilities of various management companies that are affiliated with a single nursing facility.

Establishing accountability is a challenge, in part, because of the sometimes Byzantine structures that are intentionally constructed around the long-term care facilities. The Service Employees International Union has reported, and OIG's law enforcement experiences confirm, a growing trend in the corporate restructuring of nursing home chains and other long-term care facilities to obfuscate the ownership and control of nursing homes. We have seen a variety of methods that have been used to hide the true owners that often involve the following steps: (1) creating a holding corporation to own the entire chain of nursing homes; (2) creating limited liability companies (LLCs) to manage the operations of the individual homes; (3) creating LLCs for the real estate holdings (the facility and the grounds), usually referred to as Real Estate Investment Trusts (REITs); and (4) creating an affiliated corporation to lease all of the properties from the REITs and then sublease those properties to the facility-specific entity, usually an LLC, which operates the individual homes.

The entity that acts as the facility operator does not own any assets and is authorized to use the facility under a sublease. The operating entity usually contracts with a management or administrative services company to perform the day-to-day operations of the facility. During ongoing investigations of nursing homes for the provision of substandard care, OIG has encountered nursing facilities that have as many as 17 LLCs that play a role in the operations of the facility. Such complex structures dilute accountability, greatly complicate law enforcement investigations, and delay implementation of essential corrective actions required to protect residents.

OIG Efforts To Promote and Ensure Quality of Care in Nursing Homes

The numerous oversight mechanisms used by States and CMS are primarily designed to identify and correct quality-of-care problems after they have occurred. By themselves, these mechanisms are insufficient to ensure that nursing home residents receive proper care. OIG has therefore undertaken numerous initiatives and worked closely with the nursing home industry to identify additional strategies to promote and ensure quality of care.

Encouraging Adoption of Voluntary Compliance Programs
OIG frequently provides nonbinding guidance to health care providers regarding how to establish systems and controls to promote and monitor compliance with Federal health care program requirements. Much of this voluntary guidance focuses on the importance of providing high quality health care to patients. The suggestions made in these compliance program guidances (CPG) are not mandatory, nor should they be construed as model compliance programs. Rather they offer a set of guidelines that providers should consider when developing and implementing new compliance programs or evaluating existing ones.

OIG originally published a CPG for nursing facilities in 2000, in which we provided guidance and resources to assist nursing home providers to voluntarily build systems of care and oversight. Since that time, there have been significant changes in the way nursing facilities deliver, and are reimbursed for, health care services, as well as significant changes in the Federal enforcement environment and increased concerns about quality of care in nursing facilities. In response to these developments, in April 2008, OIG published draft supplemental compliance program guidance for nursing facilities. We are currently soliciting public comments on this draft.

The draft supplemental nursing home CPG addresses major Medicare and Medicaid fraud and abuse risk areas, including quality of care, accurate claims submission, and kickbacks. The supplemental CPG focuses particular attention on such quality of care risks as inadequate staffing, poor care plan development, inappropriate use of psychotropic medications, lack of proper medication management, and resident neglect and abuse. Examples of measures that improve resident care that could be incorporated into compliance programs include:

- Regular assessment of staffing patterns to evaluate whether the facility has sufficient staff who are competent to care for the unique acuity levels of its residents;

- Policies and procedures designed to ensure an interdisciplinary and comprehensive approach to developing care plans. These can include requiring such things as completing all clinical assessments before interdisciplinary team meetings are convened, opening lines of communication between direct care providers and interdisciplinary team members, involving the resident and the residents' family members or legal guardian in discussions, and including the attending physician in the development of the resident's care plan;

- Requirements to ensure that there is an adequate indication for the use of psychotropic medication and to ensure the careful monitoring, documentation, and review of each resident's use of psychotropic drugs;

- Commitment to robust training and monitoring on a regular basis of all staff involved in prescribing, administering, and managing pharmaceuticals, and implementation of policies for maintaining accurate drug records and tracking medications; and

- Policies and procedures to prevent, investigate, and respond to instances of potential resident abuse, neglect, or mistreatment resulting from staff-on-resident abuse and neglect, and resident-on-resident abuse, including a method for staff, contractors, residents, family members, visitors and others to confidentially report any instances of abuse.

Encouraging Boards of Directors' Involvement in Compliance and Quality of Care
With a new focus on quality and patient safety, oversight of quality is a core fiduciary responsibility of health care organization boards of directors. In exercising his or her fiduciary duties, a governing board member of a health care entity can be expected to exercise general supervision and oversight of quality of care and patient safety issues. Because the support of the organization's leadership is essential to the success of any compliance program, OIG has worked collaboratively with health care industry groups to develop resources for boards of directors, including several recent efforts focusing on the role of the board in the oversight of compliance and quality of care.

In 2003, OIG and the American Health Lawyers Association (AHLA) produced a resource guide that highlighted the role that health care boards of directors can play in promoting effective compliance programs within their organizations. Another resource, published in 2004, considered the role of the general counsel in promoting an organization's compliance efforts. Most recently, in September of 2007, OIG and AHLA issued the third publication in this series, entitled "Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors." This document explores the role of health care boards of directors in responding to emerging issues related to promoting improved quality of care and patient safety. In it, we describe how compliance departments can play an integral role in aiding boards in fulfilling their oversight and decision-making obligations relating to quality-of-care issues. Some examples of possible measures that can be undertaken to strengthen the board's understanding of, and commitment to, quality of care include: (1) educating the board on emerging legal and compliance issues related to quality of care, (2) briefing the board on existing compliance systems equipped to respond to legal and regulatory quality-of-care developments, and (3) employing compliance mechanisms to implement board initiatives that seek to monitor or improve quality of care.

To further awareness of corporate responsibility and health care quality, in December 2007, OIG co-sponsored a roundtable with the Health Care Compliance Association called, "Driving for Quality in Long-Term Care: A Board of Directors Dashboard." The roundtable was an opportunity to bring together a diverse and knowledgeable group of long-term care industry and

Government representatives to generate ideas about how to effectively involve boards of directors in the oversight of quality of care in nursing homes. The participants represented a wide spectrum of long-term care organizations and professionals, including not-for-profit and for-profit organizations, multi-facility and single facility organizations, nationally and locally based organizations, clinicians, administrators, compliance officers, outside and corporate counsel, and monitors involved in OIG quality-of-care CIAs. Another goal of the roundtable was to identify information that could be included on a "Quality of Care Dashboard," a matrix, used by boards of directors as a tool for monitoring the organization's quality-of-care data.

Although it was not the purpose of the roundtable to reach consensus regarding best practices, a number of themes ran through the discussions. For example, participants consistently stated that boards of directors can demonstrate their commitment to quality resident care by establishing a forum for board-level discussions about quality; quality outcome data can help the board assess the actual performance of the organization on identified quality-of-care standards; and, where quality of care problems are identified, the response needs to be coordinated, with board oversight, to properly address the underlying cause of the problem.

Imposing Corporate Integrity Agreements

As part of the resolution of False Claims Act cases, OIG often agrees to not exclude a defendant in exchange for the defendant entering into a CIA with OIG. A CIA is a contract that imposes systems, monitoring, and reporting requirements on providers. Like all of OIG's CIAs, quality-of-care CIAs are designed to compel the strengthening of existing, or the development of, internal systems of quality assurance and communication within the monitored organization. CIAs are typically entered into for 5-year terms; the intention is that systems will be reformed and staff competence dramatically improved during the first 3 years and that the monitored organization will demonstrate that it can maintain compliance during the last 2 years.

Quality-of-care CIAs typically include the following eight key components:

1. An independent quality monitor authorized with unfettered access to facilities, staff, residents, documents, and management at every level of the organization;
2. A compliance officer who oversees all compliance systems and coordinates with OIG and the monitor;
3. Policies and procedures with an interdisciplinary focus;
4. Competency-based training requirements;
5. Internal audit functions that should continue beyond the CIA;
6. A Quality Assurance Committee (including clinical leadership and the compliance officer) to oversee clinical improvement and compliance issues throughout the organization;
7. A system of reporting information within the organization without fear of retaliation; and
8. Requirements that the organization report certain events, such as significant overpayments or serious quality-of-care problems, to the Monitor and OIG within specific timeframes.

If the entity fails to comply with the CIA, OIG may impose stipulated monetary penalties. In addition, certain violations (e.g., failing to report reportable events or to pay the independent monitor in a timely manner) may result in a breach of contract, for which exclusion of some or all of the organization may result.

The appointment of an independent quality monitor has been essential to the success of CIAs and the nursing homes' development of systems of care and oversight. The monitor is selected by OIG, or by the monitored entity with OIG's approval, sets its own budget, and is paid for by the monitored entity. These independent quality monitors effectively build upon and complement the actions of State surveyors. By using State survey results and other quality-related data, such Quality Indicators/Quality Measures derived from the Minimum Data Set, the monitors proactively identify any quality problems or systems issues that could lead to quality problems.

The success of these quality CIAs also has been a result of their access to an array of quality-of-care data. The use of a national, historical database that integrates a variety of quality measures allows the monitors to effectively compare the quality of care provided among facilities in the same corporation and to compare the quality of care in facilities from different nursing home chains. This analysis allows the monitors to track improvements or deterioration in the entity under the CIA over time and to identify areas needing a stronger focus and more resources. In consultation with the provider, the monitor recommends enhancements to systems and controls to improve quality of care. If the monitor makes a recommendation to the monitored entity, the entity must either implement the recommendation or explain to OIG its reason for failing to do so.

Over the last 7 years, many nursing home chains and individual health care facilities have agreed to operate under CIAs with independent quality monitors. Since 2002, over 1,300 health care facilities, mostly nursing homes, have operated for some period of time under quality-of-care CIAs. OIG currently has 11 CIAs with nursing homes and psychiatric facilities (or chains) with independent quality monitor requirements. These 11 CIAs cover operations in about 400 long-term care and psychiatric facilities across the country.

Conclusion and Suggestions To Promote Improved Quality of Care in Nursing Homes

Our extensive work has determined that the current mechanisms used to detect, monitor, and correct quality-of-care problems in nursing homes are insufficient. The procedural inefficiencies, communication breakdowns, inconsistent citing of deficiencies and application of remedies mean that consumers have no guarantee that the nursing home in which they place a family member provides good care or that it thoroughly screens its staff. Additionally, the program administrative oversight and enforcement systems are designed largely to identify poor care after it has already occurred. While these approaches can help to correct existing problems, they are insufficient by themselves to prevent these problems from occurring. In spite of existing oversight mechanisms, we continue to see examples of horrific treatment of nursing home residents.

Ultimately the responsibility rests with the nursing homes, and their owners and boards of directors to do everything possible to ensure that the residents in their facilities consistently receive the best possible care. I have described a number of initiatives that OIG has undertaken with the nursing home industry to promote and ensure quality of care. However, more must be done. I offer the following suggestions for consideration.

1. Improve screening of all nursing home staff by creating a nationwide centralized database that includes information from OIG's exclusions database, State nurse aide registries, and disciplinary actions by State licensing boards.

Given the dependence of nursing home residents on the nursing facility staff for their health and well-being, it is vital that providers have access to the most complete personal background information possible, including data currently residing in OIG's exclusions database and the multiple employee databases. Without this information, there is a significant risk that potentially abusive caretakers will be employed to care for this vulnerable population. With so many different sources of information, however, it can be administratively difficult and costly for a provider to ensure that it has effectively screened all of its prospective employees against all of the relevant databases. For this reason, we recommend that consideration be given to the creation of a single database that aggregates the various Federal and State sources of adverse information about direct patient access employees. We recognize that although the initial startup efforts would be resource intensive, in the long run nursing homes and other health care providers would have access to a cost-effective means of conducting a more comprehensive background check on prospective or re-check of current employees. One possible method to ensure stable funding for the continued maintenance of the centralized database would be to require that nursing homes and other potential employers check these data prior to hiring direct care staff, along with charging a user fee for access to this information. The results of the CMS criminal background check pilot program should also help to inform how such a database could be constructed and utilized.

2. Create a demonstration project to establish mandatory compliance programs for selected nursing homes.

OIG believes that the implementation of a comprehensive compliance program in nursing facilities can help achieve the goals of reducing fraud and abuse, enhancing operational functions and transparency, improving the quality of health care services, and decreasing the cost of health care. The implementation of a compliance program may not entirely eliminate fraud from the operations of a nursing facility, nor will it completely remove the specter of poor care and resident abuse. However, in our experience, an effective compliance program can significantly reduce the risk of unlawful or improper conduct. For example, nursing homes that have operated under CIAs typically report significant improvements in internal financial controls and care delivery systems. Simply put, effective compliance systems can promote improvements in quality of care. Additionally, the widespread implementation of compliance programs levels the playing field for the majority of health care organizations, which are honest and law-abiding.

A number of different approaches can be taken to achieve this objective. For example, New York now requires providers that participate in its Medicaid program to adopt effective compliance programs, designed to be compatible with the providers' characteristics. The Department of Veteran Affairs (VA) also has a robust compliance and business integrity program (CBI) for its health care systems. Although the focus of the compliance initiative is on the VA's own facilities and its employees, the CBI requires VA's independent contractors to receive formal training on compliance awareness, as well as job-specific training for physicians, clinicians, and anyone involved in the revenue cycle, either through the contractor or at the facility.

OIG suggests that the Congress work with CMS to establish and provide resources for several demonstration projects to explore different approaches to the implementation of compliance programs in nursing homes. As an example, one project could concentrate on the "special focus" facilities identified by CMS and, where appropriate, on corporations that have more than one special focus facility with a history of severe deficiencies. These nursing homes have already been identified as needing significant improvement in their quality infrastructure and would be an ideal testing ground of mandatory compliance programs. An additional demonstration project could use the nursing home's existing quality assurance committee as the starting point for building a compliance program. Such projects will help identify "best practices" and refocus the priorities of facilities that have in the past placed profit over resident care.

3. Enhance the quality-of-care data made available to the nursing home industry and the public.

Currently, CMS offers consumers and the nursing home industry a good base of information on the quality of nursing homes, primarily through its Nursing Home Compare Web site. Nursing Home Compare includes four categories of information: (1) inspection results, including deficiencies identified by Medicare certification surveys and complaint investigations; (2) facility characteristics, such as number of beds and type of ownership; (3) nursing home staffing levels; and (4) quality measures which are based on the clinical and functional status of a nursing home's residents. Information included in Nursing Home Compare can be used by consumers to select and monitor performance in nursing homes and by providers to serve as the basis for quality improvement efforts. Additionally, last month, CMS announced that it had enhanced Nursing Home Compare to identify the nursing facilities that are or have been on the CMS Special Focus Facility List. We commend this change. However, we believe that more can be done to provide critical data to the industry to enable it to better police itself. Furthermore, we believe that consumers need more detailed information about the operation of a nursing home chain or its regional components to make an educated choice about where to seek nursing care.

As described earlier, the quality monitors' oversight of corporations and individual providers under CIAs demonstrate the value and potential of using a combination of resident assessment data and survey-based performance measures to provide richer and more detailed information that corporations can use to better identify quality-related risk areas and to focus their quality improvement efforts. Until now these vital quality improvement data have been available only

to those corporations that have entered into quality of care CIAs with OIG. We believe that quality improvement in all nursing facilities can be enhanced well beyond their current capabilities by providing similar trended, comparative resident-level performance measures that that would allow facilities to "gauge" how they compare in providing quality care related to other facilities. Every corporation that OIG has monitored has indicated that its facilities have regularly used this information and have expressed concern that this comparative information is not available to them after the CIA had ended.

This concludes my statement. Thank you for the opportunity to testify today. I would be pleased to answer your questions.

Mr. STUPAK. Thank you, Mr. Morris.

Mr. Attorney General, Mr. Blumenthal, your opening statement, please, sir.

STATEMENT OF RICHARD BLUMENTHAL, ATTORNEY GENERAL, STATE OF CONNECTICUT

Mr. BLUMENTHAL. Thank you, Mr. Chairman, and I want to join in thanking you for holding this hearing and members of the Committee for devoting their time and effort, and I want to also make the point, although it probably need not be made, that we are talking about a small number of nursing homes, still a minority in this industry which is composed of many hardworking, honest, caring owners and others, and I want to make the point particularly as to those others, the staff and caregivers who work in these nursing homes. They have been not only an extraordinary and profoundly important source of care for individuals in Connecticut who are in these homes but they have also provided my investigation with exceptionally important information. They are very, very important to our investigation, whether it is the nurses or the food preparers or the maintenance workers. They have given us firsthand knowledge about the problems at Haven Health Care and similar kinds of problems throughout our nursing home industry in Connecticut.

Connecticut's very frustrating and frightening experience with Haven Health Care and it has been mentioned already, is symptomatic of a crisis that is really spreading across the Nation. It provides a clear clarion call for reform. Our present system of scrutiny is ineffective and inconsistent. It fails on two principal counts: information and enforcement. Mr. Morris has just made some very pertinent and significant recommendations as to how to improve the information availability and flow, and my testimony is about that area of concern but also about enforcement because my job as attorney general is to enforce the laws, and that is really how we became involved in the Haven Health Care problem. What it showed me very dramatically is that our current regulatory system is mired in a past era when nursing homes were owned by small, local companies or even individuals, and that regulatory system is simply inadequate, impotent to address the larger problems and challenges posed by mammoth, multi-State companies, not because they are big but because they employ an interlocking constellation of ownership, a maze of different corporate entities in different States that can be shielded from accountability, and so I have actually attached to my testimony the corporate organization chart of just one of these chains, Haven Health Care, which when it filed for bankruptcy filed individual actions for every one of the 44 entities.

Mr. STUPAK. Can you put that on the screen so others can see it?

Mr. BLUMENTHAL. It is attached to my testimony so anyone who wants it, we would be happy to make it available.

Mr. STUPAK. Thank you.

Mr. BLUMENTHAL. Haven Health Care is really a poster child for the perils of concentrated ownership and power because that consolidation of financial control enables the kind of self-dealing and self-aggrandizement for purposes unrelated to the care of patients

that occurred at Haven Health Care. To put it very simply, what we found was that the ownership and management of Haven Health Care was using its resources, either directly or as collateral for loans, to completely unrelated commercial enterprises, almost $9 million invested in a record company in Nashville, a purchase of a building there for $2.1 million, the purchase of a lakefront home in Connecticut in the town of Middlefield for close to half a million dollars, all at a time when Haven Health Care owed its vendors close to $13 million. When we talk about vendors, we are talking about companies and individuals who are essential to the quality of care at these facilities, 15 nursing homes in Connecticut, 10 in other New England States, vendors such as pharmaceutical companies, equipment suppliers, even utilities that went unpaid so that in one of them, when heating oil ran out, the individuals in the home suffered from literally freezing cold and another where electricity almost was cut off by the power company.

So the impact of fiscal mismanagement is very direct and real on patient care, and in fact, the Haven Health Care situation I think is symptomatic of exactly that phenomenon and the reason why I recommended very specific fiscal management, and scrutiny, methods of imposing it to our State legislature, which now are the basis of what I am recommending that the Federal Government ought to require of all States. I am not going to go through in detail what they are because they are in my testimony, and I know in the interests of time, some reserve is better than full explanation, but I just want to make the point that patient and resident quality of care are profoundly at risk but we are also taking about literally billions of taxpayer dollars. In the case of Haven Health Care, $130 million in Medicare and Medicaid payments annually. In Connecticut, we are talking about $1.3 billion spent in taxpayer dollars on nursing homes, obviously billions nationwide. So we owe it to taxpayers, even if they have no direct family stake as many of the Congressmen who talked about their personal experience obviously do, as we at this table do, as many in the audience do, as citizens countless of them across the country have a direct stake in the quality of care through family members, but fiscal controls are a matter of governmental responsibility and how we spend these dollars.

Let me just say finally that I strongly support the kind of information database that has been suggested by Mr. Morris and in addition I have proposed a strike force composed of Federal and State representatives that could not only monitor but take swift, strong action as well as conditions to be imposed on the States that would require State systems for monitoring fiscal mismanagement and integrity and as well prevent corporate bleeding of nursing home finances, require regulation of nursing home owners and management companies, establish minimum insurance requirements, a number of other conditions that by the end of this decade I think the Federal Government should impose on all States as a condition for governmental aid.

Where we are now with Haven Health Care is that we have restored stability, we have assured patient care. The entire interlocking corporate structure is in bankruptcy court under the jurisdiction of the judge. We have a restructuring officer and a patient

care officer who have in effect taken over operation, and it will be shortly sold after an auction to a new owner. It has been a long and hard struggle but Haven Health care has been very far from a haven. It has been in effect a house of horrors for many of the families who entrusted their loved ones to its care. It has certainly been a fiscal nightmare and a quality-of-care conundrum for all of us who have sought to pick up the pieces and restore stability and integrity, and I want to thank our State agencies, the Department of Social Services, which has been integral to this effort, as well as Federal authorities, the Office of Inspector General has been a strong partner as has been the United States Attorney.

Thank you.

[The prepared statement of Mr. Blumenthal follows:]

RICHARD BLUMENTHAL
ATTORNEY GENERAL

55 Elm Street
P.O. Box 120
Hartford, CT 06141-0120

Office of The Attorney General
State of Connecticut

TESTIMONY OF
ATTORNEY GENERAL RICHARD BLUMENTHAL
BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OF THE HOUSE COMMITTEE ON ENERGY AND COMMERCE
MAY 15, 2008

I appreciate the opportunity to speak at the Subcommittee's hearing entitled "In the Hands of Strangers: Are Nursing Home Safeguards Working?"

Connecticut's frustrating and frightening experience with Haven Health and other nursing home failures is symptomatic of a crisis spreading across the nation -- a clear, clarion call for reform. We need greatly enhanced federal-state coordination and collaboration -- a real paradigm shift. Our present system of scrutiny is ineffective and inconsistent. Even as nursing home populations rise -- with baby boomers expected to increase them exponentially -- standards and practices are sinking, and becoming as bankrupt as some of the facilities. Our regulatory system -- mired in the past when nursing homes were owned by small local companies -- is inadequate to address the problems and challenges posed by mammoth multi-state corporations, LLC's and private equity firms that dominate the industry.

Connecticut's recent rescue of financially failed nursing home chains -- particularly Haven Health -- dramatizes the problems caused by consolidation of small, single owners into large labyrinthian chains. Such firms often place profits ahead of patients, emphasizing short-term financial goals instead of long-term health care quality. Haven Health also highlights the need for improvements in federal and state government oversight of nursing homes -- increasingly nationally owned and managed by multi-state corporations or private equity partners.

Haven Health is in fact a poster child for the perils of concentrated ownership and power. Consolidation of financial control and accumulation of nursing home assets endanger accountability and integrity. The larger the chain, the greater the perils of abuse if expenses and liabilities are shared or shifted among entities. Complex webs of interlocking corporate relationships may delay and deter effective scrutiny. Nursing home financial arrangements include making private loans using nursing home assets as collateral and creating inter-connected limited liability companies to conceal the true owners and real costs. I am attaching to my testimony an organizational chart of Haven Health which clearly depicts a complex constellation of companies, impeding state regulation and oversight.

The battle against nursing home fraud and mismanagement should be two-pronged. One front should be at the federal level -- a strike force to investigate corruption or self-dealing, and

other measures combining state and federal authority to raise standards and practices. Second, at the state level, the federal government should reward or require stronger oversight mechanisms, including official state monitoring and scrutiny of nursing home finances, appointment of state court receivers for nursing homes in situations of gross financial mismanagement, bans on financial bleeding and self-dealing, mandatory levels of insurance coverage, and regulation of management companies and landlords.

Congress should:

- *Establish a Patient Protection and Financial Integrity Strike Force to rapidly investigate corruption and self-dealing and rescue nursing homes by replacing management and even ownership.* The Strike Force, within the Department of Justice, would stringently scrutinize records and reported wrongdoing, and take swift corrective action in federal or state courts. Cost recoveries and damages would be equally divided between state and federal governments. We have worked closely with the Department of Health and Human Services' Office of Inspector General on the Haven Health matter. Yet, such close coordination is lacking in many instances. A Strike Force would provide a forum for coordination of law enforcement between the federal and state governments. Each state regulates nursing homes differently and has diverse anti-fraud statutes. This task force would help break through bureaucratic or legal barriers and develop joint strategies.

- *Create a national clearinghouse of nursing home information including all state and local citations, for use by state oversight agencies.* Multi-state nursing home corporations present obstacles to state regulations because of difficulties in quickly obtaining information from other states concerning citations, investigations, license denials or discipline and other regulatory actions. A federal clearinghouse would provide states with a central source of critical data on nursing home owners and operators. This information would assist states in determining whether to heighten oversight of an existing owner or operator or deny a license or certificate to a new owner or operator.

- *Mandate simple, strict, straightforward scrutiny and safeguards -- as preconditions for enhanced federal funding -- that ensure and enable strong financial state oversight.* These would include mandatory financial monitoring by a single state official, court-appointed receivers to stop financial mismanagement, minimum insurance coverage, bars to bleeding of corporate assets, and scrutiny of nursing home management companies as well as owners.

- *Establish a Nursing Home Policy Unit, devoted to developing and requiring better standards and practices.* This unit, within the United States Department of Health and Human Services, would work with officials from each state on nursing home policy issues. One specific goal would be improved long-term financial oversight and management, and constraints on consolidation or accumulation of assets.

Consolidation and accumulation of assets raises the risks of financial abuse -- spreading a culture of non-accountability. Haven Health has finally been held accountable, but only because of our formal claims in court. Haven Health, known legally as Haven Eldercare, LLC comprises 44 separate entities, a financially failed corporate construct operating 15 Connecticut nursing homes, including Haven Health Centers in Cromwell, Danielson, East Hartford, Farmington, Jewett City, Litchfield Hills, New Haven, Norwich, Rocky Hill, Soundview, South Windsor, Waterbury, Waterford, Windham and West Hartford. It owned and operated 10 other nursing homes in New England. The corporation has allegedly grossly mismanaged millions of dollars intended for patient care, diverting federal and state money intended for patient services to improper investments in a record company and personal real estate. Severe mismanagement jeopardized the health and safety of residents at all Haven Eldercare nursing homes -- nearly 2,000 vulnerable individuals in Connecticut.

Haven Eldercare was anything but a haven. The company was financially depleted by the owner, Ray Termini, who duplicitously directed nursing home assets to a record company and other self-serving improper purposes gravely jeopardizing patient care. Haven Eldercare allegedly bled its nursing homes to near death -- apparently siphoning money from patient care, defying decency and law. No healthcare institution can be permitted to shortchange patient care services while diverting Medicaid money -- funds intended solely for patient care -- for unconscionably unrelated expenses. Haven Eldercare's practices compromised some of our state's most fragile and needful citizens.

We are now in bankruptcy court, fighting to protect millions of dollars in state funds and the well-being of Haven Health residents. After a Herculean legal battle, we have succeeded in obtaining court orders establishing a restructuring officer and patient care services officer. The financial situation has been stabilized, and we hope to have a new owner very shortly.

The federal government and the states must be more proactive, monitoring nursing home finances and watching for financial red flags, to avoid another Haven Health. On the state level, I have proposed reforms in Connecticut's nursing home regulation and oversight-- a template for national requirements. Although the proposals failed to gain approval this session, I have called for the legislature to consider them in a special session.

Federal law should establish clear accountable management mandates for every state to implement by 2013. Initially, it should provide monetary incentives to encourage states to adopt them. By the end of the decade, it should require them. States can take the initiative even sooner, raising the bar.

1. **State official monitoring of nursing home finances.** The State Comptroller or comparable state official should conduct regular financial forensic audits of nursing home operator finances to detect mismanagement and ensure that state funds are being used appropriately for patient care. The State could subpoena records, obtain testimony and review financial information of nursing home operators and their affiliates, including assets in other states. Poor performance in another state may be an indicator of potential or existing problems. A report containing fiscal findings and recommendations for action would be issued for each audit. In addition, if there is

gross financial mismanagement, the State Comptroller or other state official may recommend the appointment of a receiver

2. **State court appointed receiver upon a finding of gross financial mismanagement.** States should be authorized to seek a receiver for a nursing home operator if there is a finding of gross financial mismanagement -- defined to include having more than 35% of accounts overdue by more than 120 days or failing to pay required pension fund and health insurance contributions for more than 60 days. Currently, in many states, a receiver may be appointed only if financial mismanagement poses an imminent threat to patient care

3. **Bans on corporate bleeding of nursing home finances -- such as a statutory cap on management fees, rental payments and loan payments by the nursing home to related entities and prohibition on use of nursing home assets as a guaranty for loans unrelated to the nursing home operation.** Too often financial conglomerates arrange for their nursing home affiliates to enter contracts with related management companies or landlord companies at higher than normal rates -- exceeding levels recognized by the Medicaid program. These excessive costs undercut the financial stability of the nursing home company, leading to receivership. A statutory cap on management fees and rental payments conforming to costs allowed by Medicaid, with state authority to assess a different amount based on audited finances of the company, prevents conglomerates from viewing nursing homes as cash cows. Limits on loans secured by nursing home assets and restrictions on rent and management fees a nursing home pays to related companies enable greater state control over these byzantine corporate networks. Further, the law should prohibit the use of nursing home assets for loans, or security for loans, unrelated to the nursing home operations

4. **Require regulation of both nursing home owners and the management companies that operate the facilities and the landlords of facilities.** Landlords of nursing homes should be required to be certified, after a state agency background check and inspection of the physical plant. Management companies often are already required to obtain a permit but broader regulatory authority is critical. Further, states should have the authority to (a) suspend the management company or landlord certificate at any time for failure to maintain adequate services, (b) assess the management company or landlord civil fines of up to $15,000/violation, (c) seize civil fines directly from any Medicaid payments for management services claimed by the nursing home, (d) subpoena documents and depose witnesses as part of management company or landlord investigations; and (e) impose a receivership on the management company, landlord and other related entities involved in the operations of the nursing home.

5. **Mandatory minimum insurance coverage for nursing home owners and management companies for malpractice and liability.** While many states may require proof of coverage for liability and malpractice insurance, state statutes generally do not require a specific minimum amount. Legislation should require at least $2 million per incident with state agency discretion to require additional

coverage if it best serves the interests of the patients, families and health care providers.

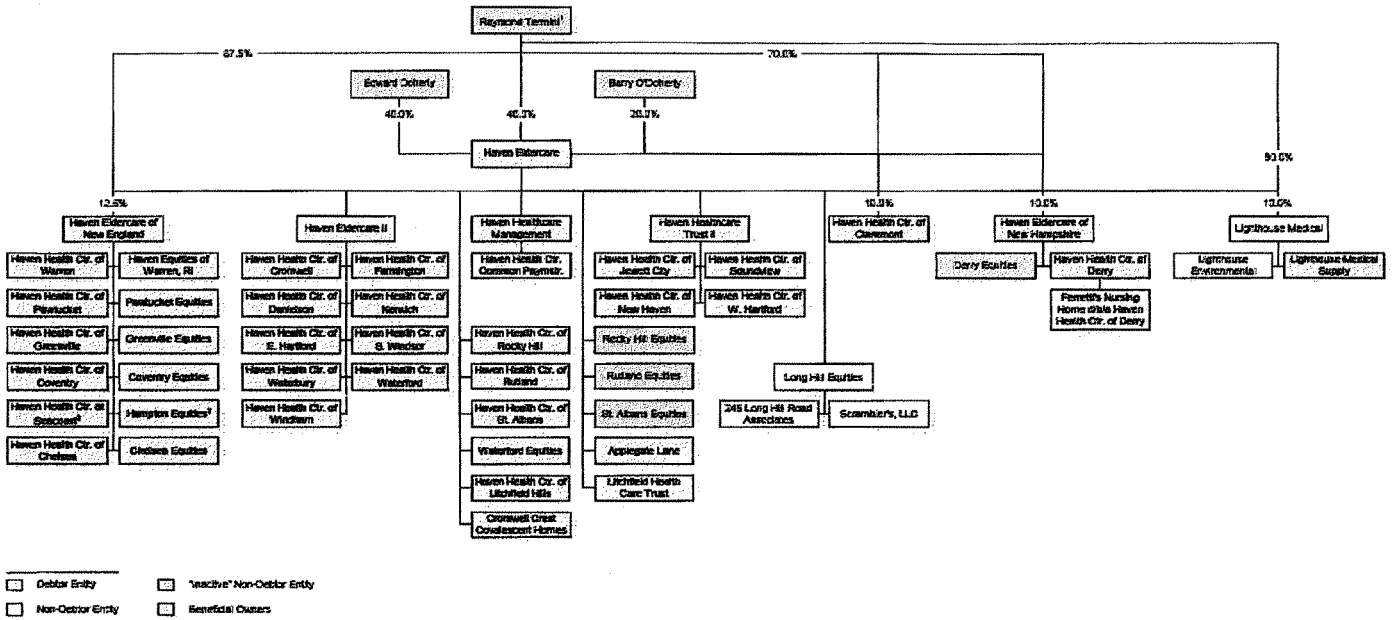
6. **Expand state approval of any change of 10% beneficial ownership of the stock of a nursing home operator to any 10% change in any beneficial ownership regardless of form of ownership.** Often control of a nursing home is dispersed among numerous limited liability corporations, affiliates, subsidiaries and wholly owned partnerships. These corporate mazes prevent state agencies from adequately evaluating the real owners. Expanding the ownership definition will ensure that state agencies must approve any change that results in a new owner of at least 10% control of the nursing home regardless of how far along the corporate chain such control shifts or whether entities other than corporations are involved.

7. **Require property owners that rent facilities to nursing homes to be responsible for physical plant repairs and maintenance.** As part of their required certificate (see recommendation #4), landlords of nursing homes should be responsible for physical plant repairs and maintenance and be subject to state orders to correct physical plant problems and to provide needed maintenance. State agencies should also be authorized to appoint building monitors with authority to do repairs and use rent payments for necessary repairs.

Finally, more resources are needed for state enforcement efforts as well as federal inspector general and oversight offices. There are simply too few investigators to adequately pursue fraudulent nursing home practices. Federal incentives and grants would encourage and fund more state resources. Federal rewards for coordination of investigations and enforcement actions would ensure that billions of federal and state taxpayer dollars provide more effective and compassionate health care for some of our most deserving citizens.

I look forward to working with this committee in this effort.

Corporate Organization Chart



Source: Court Filings

Mr. SHIMKUS. Thank you.

Mr. Navas-Migueloa of the Long-Term Care Ombudsman program for the city of Baltimore, please, your opening statement.

STATEMENT OF LUIS NAVAS-MIGUELOA, LONG-TERM CARE OMBUDSMAN; COMMISSION ON AGING AND RETIREMENT EDUCATION, CITY OF BALTIMORE

Mr. NAVAS-MIGUELOA. Good morning, distinguished members of the subcommittee, thank you for having me. It is actually quite an honor to be here. I am a long-term care ombudsman for Baltimore City. There are four of us in our office, and we advocate for the rights of residents in 31 nursing homes and over 300 assisted living facilities.

I was asked to come here and testify before you and give you some examples of how we face difficulties when coming against nursing homes who are not very transparent in their ownership. In Baltimore City, I have experienced firsthand the difficulty in helping not only the residents but also the nursing homes in solving problems which affect the care of the residents. When I am asked whether I prefer the corporate nursing home or the privately owned nursing home, I can only answer with a question, and that is, what would you rather—where would you rather go have a nice dinner, a chain restaurant or a restaurant where the chef is the owner? We encounter problems such as mouse infestations. I have actually been meeting with residents in a room where a mouse has climbed up my leg. I have seen nursing homes where there is a total of four floors in the nursing home and three of them have no working showers for the residents. I have seen nursing homes just like the attorney general mentioned where the boiler had been broken for months during the winter and the nursing home administrator had to go and buy space heaters for the residents' rooms, which are completely against COMAR regulations here in Maryland.

The difficulty that we face is that from my experience, there is a lack of human touch in the corporate nursing homes for the most part. When I go to a nursing home that is privately owned and I go up to the administrator, who is my go-to person, and I say, we have a situation, can we fix it, more often than not, the problem has either been addressed or solved before I leave the doors of that nursing home. In the less transparent ownership nursing homes, the nursing home administrator takes the role of almost like a buffer. It seems to me like there is a shield where he is either hiding problems from whoever he answers to or there is a reluctance to do a larger effort, to make a larger effort to solve the problems. I have witnessed in one nursing home four nursing assistants smoking what appeared to be marijuana and the smoke was coming into one of the resident's rooms where I was standing, and when I approached the administrator, at first he seemed very responsive and proactive about it, and after taking a minute to think, he said, why don't you call me tomorrow and we will follow up. The next day I was completely shut down from any further information. This nursing home in particular is owned by one of those large companies based out of Louisiana, I believe, and those are the challenges that we face, the lack of human touch. You sometimes won-

der if the owners have actually seen the nursing home before, and I think that is a shame because they are dealing with people and these people need help and they are not there on vacation. They live there. I hope it would be better.

Thank you.

[The prepared statement of Mr. Navas-Migueloa follows:]

Statement of Luis Navas-Migueloa
Local Long-Term Care Ombudsman, Baltimore City
Long Term Care Ombudsman Program

To the
House Energy and Commerce Committee
Subcommittee on Oversight and Investigations

"In the Hands of Strangers: Are Nursing Home Safeguards Working?"
May 15th, 2008

May 12, 2008

CARE

Helping Older Adults
Live Better in Baltimore . . .
One Day at a Time.

Testimony of
Luis Navas-Migueloa, Long-Term Care Ombudsman
Commission on Aging and Retirement Education
City of Baltimore

Good Morning Congressman John Dingell and distinguished members of the Subcommittee. My name is Luis Navas-Migueloa. I am a local Long Term Care Ombudsman with the City of Baltimore's Long-Term Care Ombudsman Program. I am joined by the manager of the Long-Term Care Ombudsman Program, Ms. Deborah Hamilton. We thank you for the opportunity to participate in today's hearing to discuss the advocacy role of the Long Term Care Ombudsman in nursing homes; and to give the committee first hand examples of cases in which the inability to access nursing home ownership has had a direct correlation to the resolution of the complaints and quality of life/care issues.

Commission on Aging & Retirement Education (CARE)

Background

The Baltimore City Commission on Aging and Retirement Education (CARE) is the designated Area Agency on Aging (AAA) for the Planning and Service Area of Baltimore City, which is the largest city in the State of Maryland. The City has the third largest senior population in the State, ranking behind Baltimore and Montgomery Counties. According to the 2000 Census, 110,961 or 13.85% of Maryland's over aged 60 population live in Baltimore City. The City's senior population tends to be somewhat older compared with that of Maryland as a whole; 9% of Baltimore's over 65 population is over age 85, compared with 8.4% statewide. Fifty-seven percent (57%) of seniors are members of minority groups; of these, 55% are African-American. Asian-Americans,

Hispanics and Native Americans each comprised less than 1% of the City's elderly population.

Baltimore City Long Term Care Ombudsman Program
Background

Baltimore City's Long-Term Care Ombudsman Program is comprised of four (4) Long Term Care Ombudsman, one (1) program manager and volunteers.

It is my responsibility as a Long Term Care Ombudsman to visit residents in Baltimore City nursing homes and assisted living facilities. On a regular basis I investigate, receive and attempt to resolve complaints made by or on behalf of residents. Additionally, as Ombudsmen we are responsible for general advocacy activities on behalf of residents, observation of conditions in facilities, meeting with family and resident councils, and providing in-service training to staff.

Our local program provides advocacy services to 31 nursing homes and 323 assisted living facilities. In 2007 we handled 661 investigative complaints, 2013 information and assistance calls and conducted eighteen (18) in-service training sessions to area nursing home staff in an effort to increase staff empathy, reduce abuse and the violation of residents rights in area long term care facilities.

Complaint issues include but are not limited to, quality of life issues, resident to resident conflicts and abuse, which range from physical, sexual and verbal abuse to lack of linens in the nursing facility. Complaints are received from residents, facility staff, visitors and

families as well as complaints generated by a Long Term Care Ombudsman during deficiencies observed during facility visits.

As a Long Term Care Ombudsman I advocate for residents of nursing homes and assisted living facilities. I identify, investigate, and resolve complaints made by or on behalf of residents; I seek administrative, legal and other remedies to protect the health, safety and rights of residents; as well as represent the perspective of the residents in monitoring laws, regulations and policies.

Testimony

Statistics show that half of us who reach 65 years of age or older will, at some point, reside in a nursing home; therefore the incidents I am sharing with you could describe any of our experiences in the future.

As a Long-Term Care Ombudsman, I have observed the difference between nursing homes owned and managed by small employers, and those owned and managed by large corporate, unknown or business enterprises. In some nursing homes the owner is identifiable, reachable and responsive. In other nursing homes, the owner is hidden by layers of corporations, management companies and boards of directors, who may or may have not ever entered the nursing home. When posed with the question of which is better from my experiences, I can only answer with an analogy: If you are looking for the best dining experience, would you rather have dinner in a chain restaurant or in one where the chef is the owner?

When dealing with the less transparent nursing home, there usually is an obvious lack of personal contact which turns into a lack of personal care and concern. There seems to be a detachment from the purpose and mission of a nursing home, which should be to take care of the most vulnerable population: the elderly and physically and mentally disabled. This detachment translates to questionable practices such as reduced staffing, poor maintenance, limited pest-control contractors, and even discrimination against residents based on payee status.

The following is an example of decision making that can adversely impact the resident's quality of life. Nursing homes attempted to force Medicaid residents to move to the older part of the nursing home while reserving the newly opened wing of the building for private-pay residents. The residents that were compelled to move were initially unaware that the proposed move was due to their payee status. Nursing home staff admitted to me that the administration made a list of Medicaid residents. They then requested that these residents be moved to the older rooms of the nursing home because the beds in the newly built building were going to be used for private pay residents. The staff member also admitted that the residents and their families had to be told that their beds were no longer being used for long-term care.

When the administrations of these nursing homes were confronted by the evidence gathered by the ombudsman, the responses differed depending on the type of ownership. The nursing home with the identifiable owner admitted to the practice, and immediately stopped it. The administrator of the nursing home with the less transparent ownership completely denied the allegations, and instead interviewed staff members to find out who

gave the information to the ombudsman regarding their practice. This is an example of how the public's lack of access to the ownership of the nursing home serves as a shield, or buffer for the nursing home administration.

The following example will show that when there is no direct access to the owner, the nursing home can take greater liberty to cover-up blatant violations. Recently, while visiting a resident in his room, I noticed a strong odor of marijuana coming from the open window. The resident and I looked out the window and I saw four female staff members at the back door of the facility smoking what smelled like marijuana. When the staff members saw me looking at them, they immediately put out their smoking paraphernalia and ran inside the building through the back door, semi-adjacent to the resident's room. The resident informed me that "they do that all the time". Knowing that the building is equipped with security cameras, I went to see the administrator. He initially appeared receptive and responsive to the concerns regarding the dangers of having direct-care staff working under the influence of drugs.

The administrator then became pensive and said that the cameras were not recording and that I should call him the next day in order to find out details of their internal investigation. As requested, the next day I called the administrator; he declined to share any information regarding the incident. In addition, he stated that after having spoken with his corporate office he could "no longer believe the allegations made by me", and the incident was now considered a personnel matter. From that point on the Ombudsman no longer was privy to subsequent information deemed necessary to protect the quality of care in this facility.

This nursing home has changed ownership at least three times in the last few years. It has always had problems related to staffing. Additionally, unattended vermin infestations and building disrepair repeatedly have been issues addressed with the administration by the ombudsman. The complaints were responded to but not completely resolved because minimum efforts were expended. For example, in lieu of calling an exterminator, in-house maintenance staff put down glue traps which were ineffective.

One day recently, only 1 of the 4 floors had fully working showers. I screened residents on several floors, many of whom reported they had no access to working showers in three weeks. This is yet another example of how a problem could have been more appropriately addressed if the owners of the nursing home were more readily accessible to residents, families and the ombudsman.

In another nursing home, financial problems caused the nursing home to cease operations. The quality of care and life of the residents was diminished for over two years. Problems uncovered included: an unpaid water bill exceeding $50,000, a malfunctioning boiler, and unpaid trash collection contractors. These debts resulted in the nursing home having to pay cash on delivery when food, supplies and other services were rendered on the premises. Overflowing outside trash collection containers and reduced staff became the norm due to mounting debts. The state regulatory agency and our program worked together and closely monitored the facility during this period.

In two and a half years of visiting this nursing home, the facility hired about six different administrators, a host of nursing directors, a handful of social work directors, and so on.

The only constant was the CEO who reportedly answered to a management company based out of Chicago and a local board of directors. This inconsistent and ever changing web of parties made it difficult and sometimes impossible to resolve some complaints.

At some point, out of frustration, the Nursing Home Administrators routinely gave a laundry list of complaints to the ombudsman. These administrators were frustrated because they also could not identify an entity to hold accountable; the Connecticut based management-company, the board of directors or the CEO. Unfortunately, the mounting problems were not resolved and the nursing home voluntarily ceased to operate August of 2007.

In conclusion, although the figure of the administrator does exist in all nursing homes, his or her role is apparently different depending on the ownership of the nursing home for which they work. Normally, the administrator is seen as the go-to person when change is needed. If I have a concern in a transparently owned nursing home and I am able to address my concerns with the administrator, it is not uncommon to have the problem solved or at least addressed prior to me leaving the facility.

When there is a problem in a nursing home with an absent owner it is difficult, and sometimes impossible to bring a resolution to problems. The administration becomes the buffer between the owners and the problems which occur in the facility.

Residents, families, and advocates in general, are limited to speaking with an individual who is either hiding problems from the ownership of the nursing home, or hiding the ownership from the people who end up suffering due to these problems.

I was not asked to offer solutions, describe the resolution process or possible sanctions. I am here to merely present the problems encountered in nursing homes by Long Term Care Ombudsman.

Again, half of us who reach the age of 65 will end up living in a nursing home.

Thank you for your time.

Mr. STUPAK. Thank you.

Mrs. Aceituno, would you like to testify at this point in time?

Ms. ACEITUNO. Yes.

Mr. STUPAK. You are recognized then, if you would please.

STATEMENT OF SUSANA ACEITUNO

Ms. ACEITUNO. Good morning. My name is Susana Aceituno. I was born in Buenos Aires, Argentina, January 27, 1933. My husband, Oscar, was born on April 1, 1929, in Buenos Aires, Argentina. We met in 1950, and after courting for some time, we got married on January 27, 1955, in Buenos Aires.

Oscar would always travel all over Europe and the States, so when we decided to leave Argentina because of personal circumstances, Oscar said we should move to the United States. In January 1966, we moved to the United States. We settled in Pleasantville, New York, with our three beautiful daughters: Laura, 8 years old; Sandra, 5 years old; and Patricia, 2 months old; and $200 in our pocket. And after much working and saving, in 1975 we were able to buy our home in White Plains, New York.

Throughout his life, Oscar was an active man. He went to Air Force school in Cordoba for 2 years, and, as I say, he would travel. He loved to play the guitar and dance the tango. He was always doing something. We never had to call a carpenter or a plumber to do anything in the house. He would garden. His life was breathing, walking, and working. He would walk many miles. He loved to walk. He would read the newspaper every day. He was never sick, very healthy, and always there for me and my girls. My nickname for him was Tarzan. He was one of the most honest human beings that I have ever known.

When he was 65 years old, he was first diagnosed with Alzheimer's. One of the signs of this illness was that he began wandering from the house. I realized how great a danger he was in when we found him in the middle of the Bronx River Parkway walking. That is when we knew we could not keep him home. It was a heart-wrenching decision but one that we took responsibly. We began researching and touring several facilities. We had Oscar examined by our doctor and by visiting nurses.

We went to Haven Health Care of Greenwich and met with the administrator. She specifically said to me, don't worry, we will take care of him. Very secure. So in May 14, 2004, Oscar became a resident of Haven Health Care. We danced a tango for the other residents and they thought we were professional dancers. The same morning, Oscar wandered out of the building one time and went outside. That afternoon at my visit, I was told by the nurse that he refused to wear the wander guard bracelet and that he wandered but they told me not to worry because they will take care of him.

For the next 2 weeks, I visited him every day with my daughters. We would eat together, we would walk outside, and we would take to other residents and staff.

In the first 4 days that he was at Haven Health Care, Oscar was allowed to leave the facility 10 times. He was not allowed. He escaped from the facility. I was told that he continued to wander throughout the day and evening and removed his wander guard

bracelet at least five times. It seemed like he was being allowed to wander. I made arrangements to move Oscar to another facility across the street. But on May 18, 2004, on Oscar's fourth day at Haven Health, I met with the administrator and she told me that Oscar was adjusting well to Haven Health and that we should let him stay there instead of transferring him. She said to give them another opportunity.

From that meeting on May 18 to May 30, I was never told anything about Oscar wandering. On May 30, 2004, at about 7:30 p.m., he was seen having escaped the building along with another resident and he was returned to his room. Twenty minutes later, he could not be located. He was found outside the health center about a mile down the road, at the side of the road at the bottom of an embankment with his face covered in mud. He was then taken to a local hospital by ambulance.

Unfortunately, the hospital did not take any X-rays of Oscar, for what reason, I don't know. They sent him back to Haven Health Center. Oscar had a bruise on his spine from falling down the embankment. The bruise was from the inside and it got swollen and cut off all his nerves in his spine. The doctors say he is a quadriplegic.

Oscar went into Haven Health Center as a strong and proud man. Since this happened, he doesn't walk, doesn't talk. He has to be fed because his hands don't work and he has had to wear diapers. I look in his eyes but he doesn't look at me. When the administrator at Haven Health came to the hospital to see Oscar, I said to her, "This is what you gave me back."

The Connecticut Department of Health investigated my husband's care and found errors committed by Haven Health Care. They were fined $615 for not looking after Oscar, but because Haven Health Care said that would be a financial hardship for them, they sent the State a check for $1.

I am happy to answer your questions and provide more information if you need it. I would like for what happened to us for something good to come out so that other people do not go through what we have gone through. Thank you very much.

[The prepared statement of Mrs. Aceituno follows:]

My name is Susana Aceituno. I was born in Buenos Aires, Argentina on January 27, 1933. My husband, Oscar, was born on April 1, 1929 in Buenos Aires, Argentina.

We met in 1950 and after courting for some time, we got married on January 27, 1955 in Buenos Aires.

Oscar would always travel all over Europe and the States. So, when we decided to leave Argentina because of personal circumstances, Oscar said we should move to the United States. In January 1966 we moved to the United States.

We settled in Pleasantville, New York, with our three beautiful daughters, Laura, Sandra and Patricia, and 200 dollars in our pockets. And after much work and saving, in 1975, we were able to buy our house in White Plains.

Throughout his life, Oscar was an active man. He went to Air Force school in Cordova for two years and as I said, he would travel. He loved to play the guitar and dance the tango. He was always doing something. We never had to call a carpenter, or a plumber to do anything in the house. He would garden. His life was breathing, walking and working. He would walk many many miles; he loved to walk. He would read the newspaper every day. He was never sick; very healthy and always there for me and our girls.

My nickname for him was Tarzan. He was one of the most honest human beings I've ever known.

When he was 65 years old he was first diagnosed with Alzheimer's. One of the signs of his illness was that he began wandering from home. I realized how great a danger he was in when we found in the middle of the Bronx River Parkway. That's when we knew we could not keep him home. It was a heart wrenching decision but one that we took on responsibly. We began researching and touring several facilities. We had Oscar examined by our doctor and by visiting nurses.

We went to Haven Health Care of Greenwich and met with the administrator. She specifically said to me "don't worry, we'll take care of him". Very secure.

So on May 14, 2004, Oscar became a resident at Haven Healthcare. We danced a tango for the other residents and they thought we were professional dancers.

That same morning, Oscar wandered out of the building one time and went outside. That afternoon, at my visit, I was told by the nurses that he refused to wear the Wanderguard bracelet and that he wandered but they told me not to worry because they'll take care of him.

For the next two weeks, I visited him every day. We would eat together, we walk outside, we would talk to other residents and staff.

In the first four days that he was at Haven Healthcare, Oscar was allowed to leave the facility 10 times. I was told that he continued to wander throughout the day and evening and removed his Wanderguard bracelet at least five times. Since it seemed like he was being allowed to wander, I made arrangements to move Oscar to another facility across the street, but, on May 18, 2004, on Oscar's fourth day at Haven Health, I met with the administrator and she told me that Oscar was adjusting well to Haven Health and that we should let him stay there instead of transferring him. She said to give them another opportunity.

From that meeting on May 18th to May 30th, I was never told anything about Oscar wandering.

On May 30, 2004, at about 7:30 pm, he was seen having escaped the building along with another resident and he was returned to his room. Twenty minutes later, he could not be located. He was found outside the health center about a mile down the road, at the side of the road, at the bottom of an embankment with his face covered in mud. He was then taken to a local hospital by ambulance.

Unfortunately, the hospital did not take any x-rays of Oscar; for what reason, I don't know. They sent him back to Haven Health Center. Oscar had a bruise on his spine from falling down the embankment. The bruise was from the inside and it got swollen and cut off all his nerves in his spine. The doctors say he is a quadriplegic.

Oscar went into Haven Health Center a strong and proud man. Since this happened, he doesn't walk; doesn't talk; he has to be fed because his hands don't work and he has had to wear diapers.

I look in his eyes but he doesn't look at me. When the administrator of Haven Health came to the hospital to see Oscar, I said to her, "this is what you give me back."

The Connecticut Department of Health investigated my husband's care and found errors committed by Haven Healthcare. They were fined $615 for not looking after Oscar. But because Haven Health Care said that would be a financial hardship for them, they sent the state a check for $1.

I am happy to answer your questions and provide more information if you need it. I would like for what happened to us for something good to come out of so that other people do not go through what we have gone through.

HAVEN HEALTH CENTER OF GREENWICH
1188 King Street P.O. Box 11029
Greenwich, CT.06831 1-203-531-8300

REPORTABLE EVENT

License Number 760-C ____CCNH ____RHNS 75 Beds

Report# 63 Classification ____A ____B ____C (D) E

Resident's Name: ACEITUNO OSCAR Age: 75

Date Admitted: 5/14/04 Diagnosis: ALZHEIMERS

Date of Event: 5/30/04 Time: 8:00 a.m./(p.m.) Location: OFF Premises

Brief description of event: Resident observed lying on ground lying on his Back on Roadside. Skin underguard intact and LT. Ankle

Assessment and Vital Signs: Alert and Verbally responsive. Full ROM in all Tour Extremities. skin dry and Intact. no SCRAPS — NO BRUISES. VS BP 148/79 R14 P80 T98.0

CIRCLE ONE:
ALARMS: (ON)/OFF RAILS: UP / DOWN FLOOR: WET / DRY SHOES: (ON) / OFF
WHEEL CHAIR LOCKED: YES / NO N/A N/A

Witness (if any) —0

Condition BEFORE event (mental, physical) Alert & Confuse. Independent Ambulatory.

Condition AFTER event (mental, physical) Alert & Confuse - Placed on Stretcher to and to ER. for evaluation

Family Notified: MULTIPLE ATTEMPTS NOT SUCCESSFULL, NO ANSWER 8PM-12AM STILL @ 7AM NO ANSWERING MACHINE Date / / Time: / a.m. / p.m.

Attending Physician: DR. Orphanos

Physician Notified: DR. TERZIG (Covering MD) Date 5/30/04 Time: 8:30 a.m. / (p.m.)

Physician examined Resident? ____YES (/) NO If YES, Date / / Time: / a.m. / p.m.

Physician findings and orders: TRANSFER to ER @ 8:20 PM FOR eval Returned @ 10:00 PM & order for Rest one day, and resume activities.

Outcome: 5/31/04 AT 8:30 AM Change in ROM upper extremities. Transfer to ER for treatment

Name of Person Filing Report: ALEJANDRO SANCHEZ Title: LPN

	YES	NO	DATE	TIME	Name of Person Notified	By Whom (Name & Title)
Resident/Report to State Allegation of Abuse						

Signature of Person Filing Report Alejandro Sanchez Date: 5/30/04
Please Print Name

Signature of Administrator ____ Date: / /
Rev. 4/03

Mary Lanson RN DON for Administrator 6/1/04

POLICE DEPARTMENT
GREENWICH, CONNECTICUT

COPY

Incident

CASE NO 04-101611

INCIDENT

INCIDENT	DV	CODE	INVESTIGATING OFFICER(S)
Casualty		305	FERRARO, JOSEPH J.

LOCATION: 1200 KING ST — APT / BLDG:

	OCCURRED	DAY	DATE	REPORTED	DAY	POST
FROM: (or ON)	05/30/2004 at 2000 hrs.	Sunday	05/30/2004		Sunday	Glenville
TO:	05/30/2004 at 2000 hrs.	Sunday	TIME: 2000 hrs.	WEATHER / LIGHT CONTIONS: Clear	CAR: 56	AREA: West

NAMES

NAME (Last, First, Middle)	DOB	SEX / RACE / ETH	SSN	DRIVERS LICENSE & STATE
ACEITUNO, OSCAR	04/01/1929	M · W · N		

ADDRESS (Street, Apartment, City, State, Zip): 1138 KING ST, B-4, GREENWICH, CT 06830 — TELEPHONE - HOME: 203/000-0000

CONTACT TYPE: EMS — EMPLOYMENT / BUSINESS ADDRESS: — TELEPHONE - WORK: 203/000-0000

NAME (Last, First, Middle)	DOB	SEX / RACE / ETH	SSN	DRIVERS LICENSE & STATE
SANCHEZ, ALEJANDRO	02/09/1969	M · B · H		

ADDRESS (Street, Apartment, City, State, Zip): 1138 KING ST, GREENWICH, CT 06830 — TELEPHONE - HOME:

CONTACT TYPE: OTHR — EMPLOYMENT / BUSINESS ADDRESS: — TELEPHONE - WORK: 203/531-8300

NAME (Last, First, Middle)	DOB	SEX / RACE / ETH	SSN	DRIVERS LICENSE & STATE
COMPERE, JANET	09/17/1952	F · B · H		

ADDRESS (Street, Apartment, City, State, Zip): 1138 KING ST, GREENWICH, CT 06830 — TELEPHONE - HOME: 203/000-0000

CONTACT TYPE: OTHR — EMPLOYMENT / BUSINESS ADDRESS: — TELEPHONE - WORK: 203/531-8300

NAME (Last, First, Middle)	DOB	SEX / RACE / ETH	SSN	DRIVERS LICENSE & STATE
BIMBA-WILLIAMS, JERI	07/20/1959	F · B · H		

ADDRESS (Street, Apartment, City, State, Zip): 1138 KING ST, GREENWICH, CT 06830 — TELEPHONE - HOME: 203/000-0000

CONTACT TYPE: OTHR — EMPLOYMENT / BUSINESS ADDRESS: — TELEPHONE - WORK: 203/531-8300

COMPUTER FILE

PROPERTY & EVIDENCE

MAKE	MODEL	SERIAL	QTY/WT	COLOR

STATUS	DESCRIPTION	COLLECT	VALUE
			$

MAKE	MODEL	SERIAL	QTY/WT	COLOR

STATUS	DESCRIPTION	COLLECT	VALUE
			$

MAKE	MODEL	SERIAL	QTY/WT	COLOR

STATUS	DESCRIPTION	COLLECT	VALUE
			$

MV

REG	STATE	YEAR	MAKE	MODEL	STYLE	COLOR

STATUS	VIN	VALUE	COLLECT
		$	

ADMIN

REPORTING OFFICER / ID #: — REVIEWED BY SUPERVISOR: — COMMANDING OFFICER: CAPT MD — CHIEF'S OFFICE: — PAGE: 1

DISTRIBUTION: ☐ TRAFFIC ENG ☐ ED ☐ SOCIAL SERVICES ☐ SELECTMAN ☐ BOARD OF ED ☐ FIRE DEPT ☐ HEALTH DEPT ☐ TOWN ATTY ☐ DPW ☐ OTHER

FOLLOW-UP ACTIONS: ☐ DETECTIVE BUREAU ☐ TRAFFIC DIVISION ☐ COURT TECHNICIAN ☐ JUVENILE OFFICER ☐ PATROL DIVISION ☐ REPORTING OFFICER ☐ CRIMES ANALYSIS ☐ OTHER

EPD DISP.		LOR CLEARANCE DISPOSITION			IF EXCEPTIONALLY CLEARED CHOOSE ONE:		DATE EXCEPTIONALLY CLEARED
CLOSED	ADMIN CLR	UNFOUNDED	ARREST	EXCEP. CLR		A-DEATH OF OFFENDER B-PROSECUTION DENIED C-EXTRADITION DENIED D-VICTIM REF. COOPERATE E-JUVENILE, NO CUSTODY	
✓							

Incident - Revision 9906

POLICE DEPARTMENT
GREENWICH, CONNECTICUT

Incident Names

CASE NO 04-101611

INCIDENT

INCIDENT	DV	CODE	INVESTIGATING OFFICER(S)
Casualty		305	FERRARO, JOSEPH J.

LOCATION	APT / BLDG
1200 KING ST	

FROM: (or ON): OCCURRED	DAY	DATE REPORTED	DAY	POST
05/30/2004 at 2000 hrs.	Sunday	05/30/2004	Sunday	Glenville

TO:	DAY	TIME	WEATHER / LIGHT CONDITIONS	CAR	AREA
05/30/2004 at 2000 hrs.	Sunday	2000 hrs.	Clear	56	West

NAMES

NAME (Last, First, Middle)	DOB	SEX / RACE / ETH	SSN	DRIVERS LICENSE & STATE
PONTICELLO, DR.		M - W - N		

ADDRESS (Street, Apartment, City, State, Zip)	TELEPHONE - HOME
GREENWICH HOSPITAL, GREENWICH, CT 06830	

CONTACT TYPE	EMPLOYMENT / BUSINESS ADDRESS	TELEPHONE - WORK
OTHR		203/622-8046

NAME (Last, First, Middle)	DOB	SEX / RACE / ETH	SSN	DRIVERS LICENSE & STATE
		- -		

ADDRESS (Street, Apartment, City, State, Zip)	TELEPHONE - HOME

CONTACT TYPE	EMPLOYMENT / BUSINESS ADDRESS	TELEPHONE - WORK

NAME (Last, First, Middle)	DOB	SEX / RACE / ETH	SSN	DRIVERS LICENSE & STATE
		- -		

ADDRESS (Street, Apartment, City, State, Zip)	TELEPHONE - HOME

CONTACT TYPE	EMPLOYMENT / BUSINESS ADDRESS	TELEPHONE - WORK

NAME (Last, First, Middle)	DOB	SEX / RACE / ETH	SSN	DRIVERS LICENSE & STATE
		- -		

ADDRESS (Street, Apartment, City, State, Zip)	TELEPHONE - HOME

CONTACT TYPE	EMPLOYMENT / BUSINESS ADDRESS	TELEPHONE - WORK

NAME (Last, First, Middle)	DOB	SEX / RACE / ETH	SSN	DRIVERS LICENSE & STATE
		- -		

ADDRESS (Street, Apartment, City, State, Zip)	TELEPHONE - HOME

CONTACT TYPE	EMPLOYMENT / BUSINESS ADDRESS	TELEPHONE - WORK

NAME (Last, First, Middle)	DOB	SEX / RACE / ETH	SSN	DRIVERS LICENSE & STATE
		- -		

ADDRESS (Street, Apartment, City, State, Zip)	TELEPHONE - HOME

CONTACT TYPE	EMPLOYMENT / BUSINESS ADDRESS	TELEPHONE - WORK

ADMIN

REPORTING OFFICER / ID	REVIEWED BY SUPERVISOR	COMMANDING OFFICER	CHIEF'S OFFICE	PAGE
				2

DISTRIBUTION: ☐ TRAFFIC ENG ☐ SOCIAL SERVICES ☐ SELECTMAN ☐ BOARD OF ED ☐ FIRE DEPT ☐ HEALTH DEPT ☐ TOWN ATTY ☐ DPW ☐ OTHER

FOLLOW-UP ACTIONS: ☐ DETECTIVE BUREAU ☐ TRAFFIC DIVISION ☐ COURT TECHNICIAN ☐ JUVENILE OFFICER ☐ PATROL DIVISION ☐ REPORTING OFFICER ☐ CRIMES ANALYSIS ☐ OTHER

GPD DISP		UCR CLEARANCE DISPOSITION			IF EXCEPTIONALLY CLEARED			DATE EXCEPTIONALLY CLEARED
CLOSED	ADMIN CLR	UNFOUNDED	ARREST	EXCEP. CLR	CHOOSE ONE:	A-DEATH OF OFFENDER B-PROSECUTION DENIED C-EXTRADITION DENIED	D-VICTIM REF. COOPERATE E-JUVENILE, NO CUSTODY	

Incident Names - New 200311

POLICE DEPARTMENT
GREENWICH, CONNECTICUT

Narrative

CASE NO 04-101611

INCIDENT

INCIDENT	CODE	INVESTIGATING OFFICER
Casualty	305	FERRARO, JOSEPH J.
LOCATION: 1200 KING ST	APT / BLDG	
NARRATIVE HEADING: ORIGINAL REPORT		DATE OF NARRATIVE: 05/30/2004

On 5-30-04 at 20:00 hours the undersigned in unit 56, P/O Mastronardi in unit 57 and Med. 3 were detailed to the area of 1200 King St. on the report of a male subject lying on the shoulder of the road.

.

Upon arrival the undersigned observed an elderly male(later identified as Oscar Aceituno) lying in a supine position with his head pointing south and his face covered in dirt along the eastern grassy shoulder of King St. approximately 10 feet north of NYT pole no 226. The Undersigned observed Aceituno to be wearing blue jeans, a pull over shirt and a pair of slip on slippers. Acietuno was located approximately 958 feet north east of the entrance / exit of the Haven Health Center driveway. The undersigned also observed a transmitter device attached to the left ankle of Aceituno.

.

Medic 3 had arrived on scene prior to the undersigns arrival and began treatment for a fall. Med. 3 transported Aceituno to Greenwich Emergency Dept. where Dr.Ponticello treated and released Aceituno for the fall.

.

While at the scene the undersigned interviewed Sanchez: he related the following that he is Aceituno nurse and that he checks on Aceituno every ten minutes to make sure he is all right. Sanchez also indicated that Aceituno suffers from Dementia and that he is a very active patient at the center.
Sanchez continued to relate that he discovered Aceituno missing around 19:50 hours on this date and that he last saw Aceituno around 19:45 hours this date. Sanchez then notified other nurses aids to assist in locating Aceituno. Sanchez was advised by nurses aid Compere that she already stopped Aceituno outside earlier around 1930 hours pushing another patient around in a wheel chair an that she brought him back inside.

.

Upon interviewing nurses aid Compere she advised the undersigned that the alarm attached to Aceituno activated when she brought him in but did not activate when he left.

.

Compere and Bimba-Williams both nurses aids went to Greenwich Hospital to await the release of Aceituno.

.

ADMIN

REPORTING OFFICER / ID	REVIEWED BY SUPERVISOR	COMMANDING OFFICER	CHIEF'S OFFICE	PAGE
				3

GROUNDS: CLOSED / ADMIN CLR	JCR CLEARANCE DISPOSITION: UNFOUNDED / ARREST / EXCEP CLR	EXCEPTIONALLY CLEARED CHOOSE ONE:	A-DEATH OF OFFENDER B-PROSECUTION DENIED C-EXTRADITION DENIED	D-VICTIM REF. COOPERATE E-JUVENILE NO CUST/DOY	DATE EXCEPTIONALLY CLEARED

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

December 16, 2004

Nicole Cadivous, Administrator
Haven Health Center of Greenwich
1188 King Street
Greenwich, CT 06831

Dear Ms. Cadivous:

An unannounced visit was made to Haven Health Center of Greenwich on September 24, 2004 by a representative of the Division of Health Systems Regulation for the purpose of conducting multiple investigations with additional information received through November 17, 2004.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visit.

You may wish to dispute the violation and you may be provided with the opportunity to be heard. If the violation is not responded to by December 30, 2004 or if a request for a meeting is not made by the stipulated date, the violation shall be deemed admitted.

Please address the violation with a prospective plan of correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

If there are any questions, please do not hesitate to contact this office.

Respectfully,

Janet M. Williams, RN

Janet M. Williams, RN
Supervising Nurse Consultant
Division of Health Systems Regulation

JMW:LLD:zbj

cc: Director of Nurses
Medical Director
President
vlhhcgreenwch.doc
CT#2954, CT#3143

Phone:
Telephone Device for the Deaf: (860) 509-7191
410 Capitol Avenue - MS #_____
P.O. Box 340308 Hartford, CT 06134
Affirmative Action / An Equal Opportunity Employer

FACILITY: Haven Health Center of Greenwich

DATE OF VISIT: September 24, 2004

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1. Resident #2's diagnoses included dementia. The MDS dated 5/25/04 identified the resident was moderately cognitively impaired, wandered, and ambulated independently. The RCP dated 6/04 reflected that the resident wandered out of the building on 8/9/04 and an approach was developed which included to place the wander bracelet on the back of the resident clothing. The physician's order dated 9/23/04 indicated to check the wander bracelet placement and function every shift. Observation on 9/24/04 with NA #5 noted the resident in the bedside chair without the wander bracelet on. Interview and observation with NA #6 on 9/24/04 reflected she found the resident's wander bracelet in the resident's hamper still pinned to the back of her camisole that had been removed the night before. Interview with RN #3 on 9/27/04 at 10:40 AM identified she believed the resident did not need to wear the wander bracelet when in bed at night.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(C).

FACILITY: Haven Health Center of Greenwich

DATE OF VISIT: September 24, 2004

Accepted 1/7/05 ZD

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1. Resident #3's diagnoses included dementia. The MDS dated 5/25/04 identified the resident was moderately cognitively impaired, wandered, and ambulated independently. The RCP dated 6/04 reflected that the resident wandered out of the building on 8/9/04 and an approach was developed which included to place the wander bracelet on the back of the resident clothing. The physician's order dated 9/23/04 indicated to check the wander bracelet placement and function every shift. Observation on 9/24/04 with NA #5 noted the resident in the bedside chair without the wander bracelet on. Interview and observation with NA #6 on 9/24/04 reflected she found the resident's wander bracelet in the resident's hamper still pinned to the back of her camisole that had been removed the night before. Interview with RN #3 on 9/27/04 at 10:40 AM identified she believed the resident did not need to wear the wander bracelet when in bed at night.

The above is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (m) Nursing Staff (2)(C).

Submission of this plan of correction does not constitute an admission or agreement as to the truth of the facts alleged or of the validity of the conclusion set forth on the aforementioned statement of deficiency.

Corrective Actions:
Resident #3 remains in the facility.

Identification:
All residents who wander are potentially at risk. All residents admitted to the facility will have a "potential elopement" assessment completed upon admission and quarterly thereafter.

System Changes:
All residents identified as a risk for elopement will have a wonder-guard placed on them.

Corrective Action:
A list of all residents who wander will be placed at each nurses' station and available to the nursing supervisor.
Nurses will document each shift checking for wander-guard placement.
11-7 Nurses will check daily that each wander-guard is working properly.
Maintenance will check the actually alarm system weekly and maintain a log.
Staff will be in serviced on systems.
QA nurse will conduct monthly audits for 3 months and quarterly thereafter on nursing documentation and maintenance logs.

Responsible Person:
DNS

Emil Coputo, Administrator 12/29/04

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

IMPORTANT NOTICE - PLEASE READ CAREFULLY

November 18, 2004

Nicole Cadovius, Administrator
Haven Health Center of Greenwich
1188 King Street
Greenwich, CT 06831

Dear Ms. Cadovius:

On **November 17, 2004** complaint investigations were concluded at your facility by the State of Connecticut, Department of Public Health, Division of Health Systems Regulation to determine if your facility was in compliance with Federal requirements for nursing homes participating in the Medicare and Medicaid programs. This survey found the most serious deficiency(ies) in your facility to be:

Isolated deficiencies that constitute actual harm that is not immediate jeopardy whereby significant corrections are required (G).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

A Plan of correction (PoC) for the deficiencies must be submitted by the 10th day after the facility receives its Statement of Deficiencies (Form CMS-2567). Your PoC serves as your written allegation of compliance. Failure to submit a signed and dated acceptable PoC by **December 1, 2004** may result in the imposition of additional remedies by the 20th day after the due date for submission of a PoC.

Each plan of correction must be written on the Statement of Deficiencies, with identification of the staff member by title who has been designated the responsibility for monitoring the individual plan of correction submitted for each deficiency. Attachments may not replace the plan of correction. A completion date is required for each item for each deficiency and shall be documented in the designated column.

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

In addition, each deficiency shall be addressed with a prospective plan of correction that includes the following components:

- **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**
- **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**
- **What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur; and,**
- **How the facility will monitor its corrective action(s) to ensure that the deficient practice will not recur, (i.e., what quality assurance or other program will be put into place to monitor the continued effectiveness of the systemic change).**
- **Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction for each deficiency and the completion date for each component.**

Your facility does not have an "opportunity to correct" the deficiencies noted prior to imposition of a remedy. However, deficiencies should be corrected by **December 29, 2004.**

Based on the deficiencies cited during your survey, we are recommending to the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State of Connecticut Department of Social Services that:

A "per-instance" civil money penalty of $1,000.00 be imposed effective **November 17, 2004.** If the Regional Office and/or the State of Connecticut Department of Social Services decides to impose the recommended civil money penalty, a notice of imposition will be sent to you.

If you do not achieve substantial compliance within 3 months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or the State of Connecticut Department of Social Services must deny payments for new admissions.

We are also recommending to the CMS Regional Office and/or the State of Connecticut Department of Social Services that your provider agreement be terminated on **May 17, 2005** if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with separate formal notification of that determination.

Allegation of Compliance
The Plan of Correction serves as your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that additional remedies be imposed by the CMS Regional Office and/or the State of Connecticut Department of Social Services beginning on **November 17, 2004** and continue and until substantial compliance is achieved. Additionally, the CMS Regional Office and/or the State of Connecticut Department of Social Services may impose a revised remedy(ies), based on changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution
In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of Substandard Quality of Care (SQC) or immediate jeopardy. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been sent found to constitute SQC or immediate jeopardy), to this office. This request must be sent during the same 10 day period you have for submitting a PoC for the cited deficiencies. Informal dispute resolution may be accomplished by telephone, review of submitted documentation or a meeting held at the Department. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If you will be accompanied by counsel, you must indicate this in you request for informal dispute resolution. You will be advised in writing of the decision related to the informal dispute.

Please return your response to the Supervising Nurse Consultant at State of Connecticut Department of Public Health, 410 Capitol Avenue, MS #12HSR, P.O. Box 340308, Hartford, CT 06134-0308 and direct your questions regarding other deficiencies and any questions concerning the instructions contained in this letter to the Supervising Nurse Consultant at (860) 509-7400.

Sincerely,

Janet M. Williams, RN
Janet M. Williams, R.N.
Supervising Nurse Consultant
Division of Health System Regulation

JMW:LLD:zbj

cc: CMS Regional Office
State of Connecticut Department of Social Services
CT #2954, CT #3143

Enclosure

Janet M. Williams, RN
Supervising Nurse Consultant
Division of Health System Regulation
State of Connecticut DPH
410 Capital Ave.
MS #12HSR
PO BOX 340308
Hartford, Ct
06134-0308

December 1, 2004

Dear Ms. Williams;

Enclosed you will find the plan of corrections for Haven Healthcare Center of Greenwich from the November 17, 2004 complaint investigation. Please feel free to contact the facility with any questions 203.531.8300. Either the DNS Mary Forzano or Nicole Cadovius the administrator will be happy to assist you.

Sincerely,

Nicole Cadovius, Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Accepted 12/3/04 ZD

PRINTED: 11/17/2004
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 11/17/2004
NAME OF PROVIDER OR SUPPLIER HAVEN HEALTH CTR OF GREENWICH		STREET ADDRESS, CITY, STATE, ZIP CODE 1188 KING ST GREENWICH, CT 06831	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 324 S=G	483.25(h)(2) QUALITY OF CARE The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, observations, and interviews for two of three sampled residents with wandering behavior (Residents #2 and #3), the facility failed to follow the resident's plan of care and/ or provide adequate supervision to prevent injury. The findings include: 1. Resident #2 was admitted to the facility on 5/14/04 with diagnoses that included Alzheimer's Syndrome and a history of wandering from home. The Minimum Data Set (MDS) dated 5/14/04 identified the resident was moderately cognitively impaired, had wandering and resistive behaviors, and was independently ambulatory. The Interim Resident Care Plan (RCP) dated 5/15/04 reflected the resident was an elopement risk with approaches that included wearing a wander bracelet and to check the resident's location every hour. Nursing Narratives dated 5/30/04 at 7:30 PM noted the resident was observed out of the building with another resident and alarms did not sound. The narratives also reflected that the resident had eloped again 20 minutes later was found lying on the street. The resident was sent to the emergency room, and returned to the facility at 10:00 PM that night. Neurological status changes were exhibited by the resident on 5/31/04 and he was admitted to the hospital with a diagnosis of spinal cord contusion. Interview with RN #3 on 9/27/04 at 10:40 AM indicted that NA #4 looked for the resident at 7:50 AM to provide 1 to 1 monitoring but that the resident could not be found. Review of Facility Policy on	F 324	Submission of this plan of correction does not constitute an admission or agreement as to the truth of the facts alleged or of the validity of the conclusion set forth on the aforementioned statement of deficiency. F324 *Corrective Actions* Resident # 2 has been discharged from facility. Resident #3 remains in the facility *Identification* All residents who wander are potentially at risk. All residents admitted to the facility will have a "potential elopement" assessment completed upon admission and quarterly thereafter. *System Changes* All residents identified as a risk for elopement will have a wander-guard placed on them. *Corrective Action* A list of all residents who wander will be placed at each nurses' station and available to the nursing supervisor. Nurses will document each shift checking for wander-guard placement. 11-7 Nurses will check daily that each wander-guard is working properly. Maintenance will check the actually alarm system weekly and maintain a log. Staff will be inservieed QA nurse will conduct monthly audits for 3 months and quarterly thereafter on nursing documentation and maintenance logs. *Responsible Person* DNS Completion Date 12.29.04	12.29.04.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/1/04

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/17/2004
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 11/17/2004
NAME OF PROVIDER OR SUPPLIER HAVEN HEALTH CTR OF GREENWICH		STREET ADDRESS, CITY, STATE, ZIP CODE 1188 KING ST GREENWICH, CT 06831	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 324	Continued From page 1 9/28/04 noted close observation might be initiated as a nursing measure for a resident that presents a serious elopement risk that compromises his safety. The resident was discharged to another rehab facility on 6/4/04 with cervical collar in place and the possibility of impending neurosurgery. 2. Resident #3's diagnoses included dementia. The MDS dated 5/25/04 identified the resident was moderately cognitively impaired, wandered, and ambulated independently. The RCP dated 6/04 reflected that the resident wandered out of the building on 8/9/04 and an approach was developed which included to place the wander bracelet on the back of the resident clothing. The physician's order dated 9/23/04 indicated to check the wander bracelet placement and function every shift. Observation on 9/24/04 with NA #5 noted the resident in the bedside chair without the wander bracelet on. Interview and observation with NA #6 on 9/24/04 reflected she found the resident's wander bracelet in the resident's hamper still pinned to the back of her camisole that had been removed the night before. Interview with RN #3 on 9/27/04 at 10:40 AM identified she believed the resident did not need to wear the wander bracelet when in bed at night.	F 324		

CERTIFIED MAIL

CITATION

In Re Citation No. 2004-240

Classification of Violation
Pursuant to Connecticut
General Statutes Section 19a-527

Date: December 16, 2004

Class: B
Bed Capacity: 75
License Number: 760-C

Licensee: Laurel Convalescent Home, Inc. of Greenwich, CT.
Facility Name: Haven Health Center of Greenwich
Facility Address: 1188 King Street
Greenwich, CT 06831

The following citation is issued pursuant to Sections 19a-524 through 19a-528, inclusive of the Connecticut General Statutes:

A. Nature and Scope of Violation(s):

1. An inspection of this facility which concluded on (date) revealed the following:
   a. Alzheimer's Syndrome and a history of wandering from home. The Minimum Data Set (MDS) dated 5/14/04 identified the resident was moderately cognitively impaired, had wandering and resistive behaviors, and was independently ambulatory. The Interim Resident Care Plan (RCP) dated 5/15/04 reflected the resident was an elopement risk with approaches that included wearing a wander bracelet and to check the resident's location every hour. Nursing Narratives dated 5/30/04 at 7:30 PM noted the resident was observed out of the building with another resident and alarms did not sound. The narratives also reflected that the resident had eloped again 20 minutes later was found lying on the street. The resident was sent to the emergency room, and returned to the facility at 10:00 PM that night. Neurological status changes were exhibited by the resident on 5/31/04 and he was admitted to the hospital. The resident's radiological exam of 5/31/04 was consistent with cervical cord contusion. Interview with RN #3 on 9/27/04 at 10:40 AM indicted that NA #4 looked for the resident at 7:50 AM to provide 1 to 1 monitoring but that the resident could not be found. Review of Facility Policy on 9/28/04 noted close observation might be initiated as a nursing measure for a resident that presents a serious elopement risk that compromises his safety. Review of the resident's clinical record identified that the resident's plan of care

had not been changed to keep the resident safe and prevent the second elopement that resulted in injury.

B. Statutes and/or Regulations Violated:
Regulation of Connecticut State Agencies (Public Health Code) violated is,
Section 19-13-D8t (j)(2).

C. Classification of Violation(s)
Class B in accordance with Section 19a-527-1 (b)(6) of the Regulations of Connecticut State Agencies (Public Health Code).

D. Amount of Civil Penalty to be imposed in accordance with Connecticut General Statutes Sections 19a-527 and 19a-528: $615.00

NOTIFICATION OF ELECTION TO CONTEST CITATION

If the licensee wishes to contest this Citation, the administrator or his designee must within three days, excluding Saturdays, Sundays and holidays, of receipt of the Citation by the licensee, shall notify the Supervising Nurse Consultant who signed the citation by contacting the Division of Health Systems Regulation (DHSR), Department of Public Health, 410 Capitol Avenue, MS#12 HSR, P.O. Box 340308, Hartford, Connecticut 06134-0308, telephone number (860) 509-7400 or any Supervising Nurse Consultant within DHSR (same address, same telephone number).

ELECTION NOT TO CONTEST CITATION

Should the licensee not wish to contest this Citation and pay the civil penalty, check or money order should be made payable to: Treasurer, State of Connecticut, attention Joan D. Leavitt, PHSM and sent to the above identified address.

IF THE ADMINISTRATOR FAILS TO SO NOTIFY THE DEPARTMENT, THE CITATION SHALL BE DEEMED A FINAL ORDER OF THE COMMISSIONER OF PUBLIC HEALTH, EFFECTIVE UPON THE EXPIRATION OF THE THREE DAY PERIOD REFERENCED ABOVE. CONNECTICUT GENERAL STATUTES SECTION 19a-525(a).

INFORMAL CONFERENCE

If the administrator has notified the Department in accordance with the procedure set forth above, an informal conference will be conducted as required by Section 19a-525(b) between the licensee and the Commissioner or his designee. The facility may wish to be represented by an attorney.

Licensee: Laurel Convalescent Home Inc. of Greenwich, CT.
Page: 3

POSTING REQUIREMENT

Each Class A or Class B Citation shall be prominently posted in the nursing home cited so as to be visible to any resident, including those in wheelchairs and to any employee or visitor of the nursing home until the violation has been corrected to the satisfaction of the Commissioner of Public Health or the Citation has been vacated by the Commissioner. Failure to comply with this requirement constitutes a violation of Connecticut General Statutes Section 19a-540.

Signature: Janet M. Williams, RN

Date: 12/16/04

JMW:LLD:zbj

cc: Nicole M. Cardovias, Administrator
Richard Lynch, Assistant Attorney General
Marianne Horn, Director
Joan D. Leavitt, Public Health Services Manager
Janet M. Williams, Supervising Nurse Consultant
Laura Doyle, Nurse Consultant
David DeMaio, Health Program Associate

Mr. STUPAK. Thank you, and thank you for your testimony. We know how difficult it was for you.

We will begin with questions here. Mr. Morris, if I may, I will begin with you, a couple questions, if I may. Is it fair to say that information about who owns and controls a hospital is helpful to regulators at all levels in the government?

Mr. MORRIS. Information about ownership is critical to both promoting compliance and our enforcement efforts. Our experience has been that when we are looking into substandard care provided by nursing homes, one of the enormous challenges we face is navigating through the corporate structure that is put up to deflect responsibility from those who have made resource decisions. I would suggest that while transparency is a critical part of improving care and supporting our enforcement efforts, it is a means to an end. The end is improving quality. And so we would submit that a compliance program which gets critical information up to decision makers, up to shareholders and those who actually are controlling the resources of a chain, is essential. Knowing who they are is critically important. Getting them that information so they can be held accountable if they don't act on it is equally important.

Mr. STUPAK. CMS has undertaken a program called PECOS, which should help to ensure ownership accountability. Has your agency looked at PECOS and its implementation and has it achieved its goals?

Mr. MORRIS. We have not recently looked at PECOS as part of our evaluative effort. I believe one of the concerns that we have with PECOS is how many layers of accountability it captures, and we have seen in our investigations and some of the investigative journalism reports, there are so many layers between the individual facility with which CMS has its provider agreement and those who are really calling the shots, PECOS does not capture that number of different indirect owners. So it is part of the solution but it is not a comprehensive solution.

Mr. STUPAK. Let me ask you this question. How do compliance programs work in conjunction with a voluntary industry standard? I know the nursing homes have been doing an "Advancing Excellence" campaign. How do you look at that with your compliance as a regulator? Do they complement each other? Can it help? Explain that a little bit.

Mr. MORRIS. Certainly. They certainly can complement each other. The nursing home industry should be applauded for the steps it has taken to promote voluntary efforts to improve care. In our experience, a compliance program has as its cornerstone integrity, financial integrity, and integrity over clinical care. That is what makes a compliance program such a powerful tool. I would suggest the next step towards advancing care, is that you mandate certain components of a compliance program. You empower a compliance officer to, if you will, speak truth to power. You build in internal systems to get the root cause analysis. To come back to the transparency point, you empower the compliance officer to bring that information to those who actually make resource decisions. So while we applaud what the nursing home industry has done, we think much more can be done to promote quality through compliance programs.

Mr. STUPAK. Let me ask you——

Mr. MORRIS. We would suggest, for example, that a demonstration project mandating compliance programs would be a good start.

Mr. STUPAK. Let me ask you, because you testified that the OIG is continuing its oversight of the use of antipsychotic drugs in nursing homes. Has your investigation—what has your investigation found? More use, less use? What have you found? And it is ongoing, I take it?

Mr. MORRIS. That work is still ongoing so it would be premature for me to report on its results. We would be pleased to come back to you once that work is completed.

Mr. STUPAK. Mr. Attorney General, you have recommended the creation of a national clearinghouse of nursing home information. Why isn't the current information which CMS maintains on nursing homes adequate?

Mr. BLUMENTHAL. Mr. Chairman, I think it is inadequate because of a number of factors, first of all, because it is incomplete in many respects, it fails to encompass or capture the real owners of nursing homes. The kind of labyrinthine maze of corporate structure that many of the chains now have prevents that database from being fully current or accurate. But equally important, there are issues about its availability to the States, the access that State regulators may have to it. For example, our Department of Public Health, our Department of Social Services may not have full, current information about citations, investigations, license denials, disciplinary proceedings, simply because it fails to capture all that data or make it available in a timely way to the States. So I think the States should be a partner in that kind of national clearinghouse rather than just a bystander. In the case of Haven Health Care, for example, numerous violations occurred, repeated in some of the nursing homes, 45 in the course of 3 years involving very severe issues of patient care. I am doubtful that any of those kinds of citations or incidents appeared in the database that exists now even though Haven Health Care was operating 10 nursing homes in other New England States. So I think that again coming back to the present perils of concentrated ownership and power, we need a different paradigm to deal with them in terms of information gathering and enforcement.

Mr. STUPAK. Well, you are the top law enforcement agent in the State of Connecticut and you have been there longer than Haven has had ownership of these; was there no central base for you to go to as the chief law enforcement officer of Connecticut to look to as you began your investigation in Haven to say, gee, we have a problem here and this is the exception, not the rule for—how did you gather the information about the 45 violations over 3 years? Did you have to go back and hand-create that database?

Mr. BLUMENTHAL. Well, we were aware of the problems that Haven Health Care, certainly the financial problems and some of the healthcare issues, and one of the recommendations that I have made is that fiscal problems and gross mismanagement be sufficient reason in effect to intervene and establish a receiver under State court proceedings. Present laws simply fail to give law enforcement the power it needs to prevent the recurrence of these problems. Fines and penalties are all too often simply regarded as

a cost of doing business, and very often, as happened in Haven Health Care and Ms. Aceituno's case, the nursing home operator will make the case to regulators that a financial penalty will actually diminish the quality of healthcare because it diminishes the resources available for healthcare. And so my pitch to the committee basically is, we need stronger means of preventing gross mismanagement or self-dealing and bleeding of resources before it occurs because, as happened with Haven Health Care, we were aware of its problems back in 2006. We urged the Department of Social Services to seek a receiver. It had reasons for declining our recommendation. But we would have been probably better off with earlier intervention, a better standard, a better means of imposing control such as a receiver or joint Federal-State action.

Mr. STUPAK. And Haven Health Care is the exception, not the rule of nursing homes, I think you said in your testimony. Is that the case?

Mr. BLUMENTHAL. Well, it is an exception. You know, we have intervened and we have done in our State criminal prosecutions of fraud. We have also done receivers for other nursing homes. We just, as a matter of fact, established a receiver for a nursing home chain called Marathon, which has a number of homes both in Connecticut and Massachusetts, which then went to bankruptcy court, and very often the bankruptcy court structure itself can impose delay and confusion on the process. It took us literally months of a team of our lawyers, three or four of our lawyers, going to repeated bankruptcy court proceedings, working with creditors, secured creditors, a very complicated process but I think what we will find is that more and more these nursing homes will seek the refuge of bankruptcy court, as they are legally entitled to do, in order to avoid more effective State intervention unless this committee establishes some of the recommendations that are being made.

Mr. STUPAK. Thank you, and I am over my time, and we will go for a second round of questions.

Mr. Shimkus for questions, please.

Mr. SHIMKUS. Thank you, Mr. Chairman.

Mrs. Aceituno, thank you for sharing your story. You said you had shopped around for a nursing home for your husband, Oscar. In that searching, were there any signs that this particular nursing home—I mean, talk through that process. The whole issue is information, so were you concerned? Again, in rural America they may only have one choice and there may be——

Ms. ACEITUNO. No, I liked the nursing home because it was a small one like a home. So the big, big nursing home, I didn't know too much about them. I guess I should have found something, you know, more important what happened in the nursing home. Today I open my eyes more because I know what is going on. But I liked the place because it was like home. It was close to my house too. I used to visit him every day together with my daughters. I never expected that to happen.

Mr. SHIMKUS. CMS, and we hope they elaborate more. We are trying to get more information. There is a Web site. I think there is going to be a question about how much information is available, what is accessible for the consumers, what might be accessible in

addition to for local law enforcement or inspector generals or AGs of various States.

Mr. Morris, can you talk about the Web site and information about maybe information that is available that is not available to everybody?

Mr. MORRIS. I would be glad to, and I would also note that Dr. David Zimmerman will be appearing on the next panel, who has a great depth of expertise around the quality indicators and how they can be used effectively. The suggestions coming from the inspector general are aimed at putting the information that is available in context so that a consumer or an enforcement agency and, equally important, the industry itself can look at the information, see how a facility is doing relative to its peers so there is a context, so consumers can read the information and understand what the deficiencies mean in the context of overall care. And equally important, provide consumers and the industry with trending information so you know how this facility and the chain it is a part of has done over time. One of the things we have seen is that many facilities are what are called yo-yo facilities that come in and out of compliance. So if you happen to take a snapshot while they are in compliance, it may not tell you everything you need to know.

Mr. SHIMKUS. And I think we have experienced that quite a bit, especially in the inspection regime based upon a pop inspection versus one that somehow they know is coming. There are preparatory actions. You know, we did that in the military when we knew our IG was coming around. And that is what we need to address too is this yo-yo effect.

Mrs. Aceituno, you testified about the penalty and that the company only had to pay $1. Based upon your experience, what should have happened to that nursing home?

Ms. ACEITUNO. What should happen?

Mr. SHIMKUS. Yes. I mean, they were fined $615. I think that my perspective would be, that is small, and then they only paid $1, which is even less.

Ms. ACEITUNO. He was a $1 man. I think people should have more information about what they expect from the nursing home and what they require from the nursing home. And I really hope you can change the law and be a little more tough about this. I not only lost my husband but the father of my daughters, a grandfather. He was a great man. He was very, very happy to be an American. Nobody could say anything about America because he would turn around and say listen, the airport is open; if you don't like America, go home. That was my husband.

Mr. SHIMKUS. Yes, I wish I would have had a chance to meet him. I think I would have been proud to welcome him here.

Mr. Blumenthal, in this briefing book there is a lot of different tabs and stuff and one talks about the Hartford Current doing a story on the nursing home in 2006. I guess the question—and you kind of raised it with the chairman, with all these signals being raised, what could you all have done more? Was there more that you could do just in the State with State rules and State laws?

Mr. BLUMENTHAL. Even with existing State law, to be very blunt, we could have sought a receiver, that is, a State takeover through a State court action earlier than we did, and it is now a matter of

public record that my office recommended a State takeover earlier than was done, and our State Department of Social Services, which has the ultimate authority through its approval process to undertake that action, declined to adopt the recommendation. But the Hartford Current article has certainly performed an enormously important service in raising public awareness about these problems.

Mr. SHIMKUS. Yes, and I appreciate—we are just trying to follow the facts to help us in the public policy arena, and raise education, even among public policy people in the executive branch so they do the job, and this is obviously one that could have been done better by a lot of people.

Let me just raise, because this is a concern in Illinois right now, and first I will start with Mr. Blumenthal because I don't know what the State FMAP is, which the FMAP is the percentage of reimbursement versus what we pay on Medicaid. Illinois is a 50/50 State. Other States, their share is different, and I have a big beef about that, to begin with. But being a 50/50 State, there are two problems. One, and a lot of care in these facilities are Medicaid recipients, if we do not fund based upon a percentage, then what Illinois has to do is, we have to find the loopholes to game the system to try to bring more money in. So I don't know what Connecticut's is. That is the first question. The second question is, we have a particular problem in Illinois because the State is the payer. They get the money back. They get their portion back. But if they delay payment, in some cases right now in the State of Illinois for 4, 5, 6 months, that really kills financially some of these facilities because then they are trying to—how do you run a business when you have this delay in payment? So do you know—I am not trying to put you on the spot. Do you know the State's rate?

Mr. BLUMENTHAL. If I may answer your question, we have, I believe, as well a 50/50 match.

Mr. SHIMKUS. You know, there are some States that have 70/30?

Mr. BLUMENTHAL. Right, and I think that observation, and I think it is a very pertinent one on your part, emphasizes the importance of our working together and recognizing the complexities of these issues. I have recommended, for example, in my testimony that a 10 percent change in beneficial ownership trigger additional monitoring or review. If that process had been in effect when Ray Termini, who came to be the owner, took over, it would have been found that he had no experience in this industry other than repairing the roofs on some of the facilities. It would have prompted stronger oversight and monitoring, which I believe is necessary, and you are absolutely right that suspending or withholding money may be problematic for some of these institutions, which is why——

Mr. SHIMKUS. Do you know the State's time frame of payment? I will stop with that one, Mr. Chairman. Do you know how long it is that the State of Connecticut pays on the obligation for Medicaid for long-term care?

Mr. BLUMENTHAL. How long it——

Mr. SHIMKUS. Well, again, I only know my State. We are probably 4 months behind.

Mr. BLUMENTHAL. I feel a little insecure answering. I believe——

Mr. SHIMKUS. That is fine. I am not trying to put you on the spot. I am just——

Mr. BLUMENTHAL. I believe we are current.

Mr. SHIMKUS. It is a problem in this industry and throughout healthcare across the Nation when reimbursements are not made in a timely manner. I am indicting my own State because of my State's failure. I just don't know how prevalent it is in some of the other States.

Thank you, Mr. Chairman.

Mr. BLUMENTHAL. I don't know what the experience in Illinois is but let me just make a very important point to you, that very often these institutions in financial trouble are advanced money, not suspended by advanced money, and I would wager that happens in a lot of other States as well and the critical decision that our agency would have to make is whether to advance more money, in other words, throw good money after bad, good money being for the care of patients, but possibly for exploitation as well.

Mr. STUPAK. I thank the gentleman.

Ms. Schakowsky for questions. Your opening will be made part of the record. I noted earlier you were here and you were bouncing back and forth between the Health Subcommittee, so we appreciate you being here.

Ms. SCHAKOWSKY. Thank you so much, and I do apologize for not having been here for the testimony. I have looked at the testimony and my staff is here and I was able to get the end of Ms. Aceituno's testimony, which was very, very moving.

Mr. Morris, isn't it the case that CMS currently has no centralized database from which State officials can easily find information about nursing home companies moving into their States?

Mr. MORRIS. I couldn't speak to that directly. I believe Acting Administrator Weems will be testifying later. There is data available through PECOS which identifies immediate owners of facilities. As we were discussing a couple of moments ago, the big difficulty is being able to follow that ownership upstream through multiple——

Ms. SCHAKOWSKY. Well, let me ask you this, then. I think we are going to hear later from CMS that they only have information on about 70 percent of nursing home providers in the country and they are going to tell us that it focuses on the quality of care nursing home residents receive without regard to ownership. What difference does it make whether CMS has complete information about corporate ownership of a nursing home chain?

Mr. MORRIS. I think it makes a difference because the government should know who it is doing business with, and if the benefit of the bargain, the money we pay for services, is not being met, we should be able to go to those who have received our money through ownership interests and hidden shells and be able to have a conversation with them and hold them accountable if they don't improve the care of the residents for whom we are charged with looking after. So I think it makes it a huge amount of difference.

Ms. SCHAKOWSKY. So would everyone on the panel agree that that information should be part of the searchable database? Does anybody want to comment? No? OK.

Let me ask Mr. Blumenthal, the owner of Haven Health Care, Ray Termini, borrowed against the equity value of the real estate

in his nursing home to finance really extravagant ventures such as the purchase of a recording studio in Nashville, Tennessee. Why do owners such as Mr. Termini attempt to separate the ownership and operators of a nursing home? What is the economic rationale?

Mr. BLUMENTHAL. For permitting them to have ownership or for his doing what he did?

Ms. SCHAKOWSKY. His doing what he did, really.

Mr. BLUMENTHAL. Well, you are asking the wrong person for a defense here.

Ms. SCHAKOWSKY. Well, let me ask you this. Is it a problem for an owner to use a nursing home's equity to finance non-healthcare-related ventures, in your view?

Mr. BLUMENTHAL. And I apologize. I didn't mean to be facetious. It is a very serious question, and for us, a very real one, and in fact, we are continuing our investigation. There has been public mention, I can't comment on it, that Federal authorities may be involved as well, but the use of that money for unrelated purposes raises very serious and significant legal exposure for him, and in my view, there is simply no rationale for it. There is no excusable reason for resources to be taken from a nursing home enterprise, as we alleged he did, for a recording company or a private home or other unrelated ventures, whether extravagant or not, and risking the financial liability of the nursing home.

Ms. SCHAKOWSKY. And then to claim that $651 or whatever it was is just too much for him to pay, I think that is a pretty insulting fine to begin with but to send $1 is absolutely despicable, in my view.

Mr. BLUMENTHAL. And your question goes exactly—I think it is a very good illustration of the practical consequences of the separation of these different entities into different corporate structures so that they can be insulated from accountability, and I know that Ms. Aceituno's attorneys are here today, they are seeking recovery, and by the way, others have sought recovery through malpractice actions, and one of my recommendations is that there be minimum insurance requirements so that people who are in this situation can hold accountable these——

Ms. SCHAKOWSKY. There are no minimum insurance requirements at all now?

Mr. BLUMENTHAL. They differ from State to State and they are inadequate in most States.

Ms. SCHAKOWSKY. Well, thank you for that suggestion.

I want to ask Mr. Navas-Migueloa, you indicate in your testimony when nursing home ownership is transparent, it is easy for the ombudsman—and I really appreciate the work of ombudsmen, we have some in our community—to prompt improvement in a nursing home. How often do you find that non-transparency is a problem in the homes that you visit?

Mr. NAVAS-MIGUELOA. Non-transparency?

Ms. SCHAKOWSKY. Yes.

Mr. NAVAS-MIGUELOA. I would say between a handful and a dozen nursing homes out of 31 are difficult to intertwine who runs it. In some nursing homes, you have a conglomerate, it is a mesh. You have an administrator, a CEO, a board of directors, some management company from out of state, et cetera, et cetera, et cetera.

Ms. SCHAKOWSKY. So if you encounter a non-transparent home, what steps does your office take to determine who the owner is?

Mr. NAVAS-MIGUELOA. From our office ourselves, we do all the research we can do from calling the administrator to trying to decipher who owns the place. In some cases the administrator will actually look at you and say I am not quite sure, I think they are a company out of Chicago but we also have a CEO who may be able to help you, and it is quite frustrating and I understand that they are running a business, for better or worse, and I know that my role is in the trenches and I understand that there is bigger agencies involved and I hope that somebody knows.

Ms. SCHAKOWSKY. Well, Mr. Chairman, may I ask a couple more questions?

Mr. STUPAK. Yes, a few more.

Ms. SCHAKOWSKY. Thank you.

If you are dealing with a nursing home that had a record of poor performance in another State, would you have any way of finding out, and how would you do it now?

Mr. NAVAS-MIGUELOA. Unless there was a warning, I wouldn't know.

Ms. SCHAKOWSKY. You wouldn't know, and is there any way you could find out?

Mr. NAVAS-MIGUELOA. I am not terribly sure.

Ms. SCHAKOWSKY. What has your experience been with nursing homes that are purchased by companies that are based out of your State? Is there any difference in the quality of care that you have noticed?

Mr. NAVAS-MIGUELOA. The quality of care, I guess that is a question that the residents should answer. I am not one to say that quality of care is better than this one. I guess it depends on what the resident expects is quality of care.

Ms. SCHAKOWSKY. Well, you do have a standard, I hope, of——

Mr. NAVAS-MIGUELOA. Sure, but I am not going to put words in the residents' mouths.

Ms. SCHAKOWSKY. No, but I mean, do you find—well, this is an important issue.

Mr. NAVAS-MIGUELOA. Sure, absolutely.

Ms. SCHAKOWSKY. I mean, do you find more substandard care? Have you noticed any difference between those that are part of an outside of your State chain?

Mr. NAVAS-MIGUELOA. Yes.

Ms. SCHAKOWSKY. What kind of steps do you think that Federal regulators could take to most assist your work in dealing with non-transparent nursing homes? This is my last question.

Mr. NAVAS-MIGUELOA. Allowing us to know who to go to, allowing us to know who the owners are so that if we have to go far and beyond the administrator who is our contact person, we know where to go, we know who to call, we know who to approach to solve a problem, like not having showers in the nursing home.

Ms. SCHAKOWSKY. Let me just ask Mr. Blumenthal to answer that too.

Mr. BLUMENTHAL. As you just heard, the information sharing is completely inadequate, and what I would like to see is that the Federal Government establish a clearinghouse, a database that is

freely accessible to regulators and perhaps even proactively warns State regulators about owners, operators, managers who have encountered problems. You know, we are not talking about rocket science, to use an overused term. It is a very simple concept that this information be freely available and that there be joint State-Federal enforcement and that the Federal Government absolutely require as a precondition for providing all those billions of dollars that you do, that the State do an adequate job of monitoring, that it require people, adequate numbers of inspectors and the kind of enforcers who will protect again the Haven Health Care kind of situation. Thank you.

Mr. STUPAK. Mr. Whitfield for questions, please. If you run over, that is fine. We have five votes coming up but go ahead and get started.

Mr. WHITFIELD. Mr. Chairman, thank you, and I certainly want to thank the panel for being with us today.

Mr. Morris, I was just glancing at the New York Times coverage today of this hearing, and it says that there is widespread understatement of deficiencies in the nursing home business, and then you are quoted also as saying, "We found nursing home residents who are grossly dehydrated or malnourished. We found maggot infestations in wounds and dead flesh," and so forth, and I was just wondering, Number one, in conducting this report or submitting this report, how many States did you go in and look at nursing homes in those States, and from your perspective, what portion of nursing homes do you feel are not meeting minimum standards in our country today?

Mr. MORRIS. Let me try to answer the question this way. I believe the Times article you are referring to, today's article, was actually talking about a report issued by the GAO today so we were not part of that evaluative effort. However, as part of our audits and evaluations, we look at facilities throughout the country, all 50 States and use those to base our findings and recommendations. In the particular matters that you are addressing, we work very close with State and Federal law enforcement officials in every State. We work with the State Medicaid fraud control units. They are really on the front line of these enforcement efforts. So we bring all of that enforcement information as well as our evaluative work.

To the question of how many facilities, how many chains are providing substandard care, we would note that the empirical evidence suggests about one in five is providing care that puts residents in harm's way, either putting them in jeopardy or providing actual harm. We would also note that many of these facilities yo-yo in and out of compliance with program requirements so the magnitude of the problem when looked over a multi-year period is probably more dramatic than that.

Mr. WHITFIELD. So you are saying that 20 percent of the nursing homes in the country are endangering the patients today in the care that they are providing?

Mr. MORRIS. Based on the survey information coming out of both the State and Federal surveyors, yes.

Mr. WHITFIELD. Now, when we talk about Federal standards, meeting Federal standards, what does that term actually mean?

Can you delineate some of the different types of standards that we are referring to?

Mr. MORRIS. Well, the Centers for Medicare and Medicaid Services have conditions of participation which specify both patient care as well as life safety requirements that nursing homes are required to meet in order to participate in our program, and those are the standards from which we in the Federal Government and then our partners in the State use to evaluate whether a particular facility is in compliance. There is a State survey process by which each facility is subject to on average about 15 months of survey reviews and then the Federal surveyors go back and review some portion of that work to see whether the quality of those surveys is adequate and consistent.

Mr. WHITFIELD. Now, I want to go back to this owners issue for just a minute. A nursing home is either meeting the requirements or it is not. It is either providing care at a certain standard or it is not. So why is the ownership aspect of it so important?

Mr. MORRIS. The ownership aspect is important because care is delivered through a range of different mediums and the quality of care varies throughout the week and year. When we see systemic failures of care, it means something is wrong with how that nursing home is delivering care not to just one individual but across the board. When we in the enforcement community and the compliance improvement community want to have a conversation about how to improve care, we need to find who has got control of the resources. Our experience has been that when a facility is under the control of a large corporation which has put multiple layers of accountability between decision makers and the facility, resources are drained away from care so we need to be able to have transparency and accountability with those who actually make the resource decisions. As was alluded to in this panel, many times when we speak to the head of the facility, they don't know who is in charge. They don't know how to respond to an ombudsman's concern or a State surveyor's concern. It is always passed uphill. They may not know who has got control over those resources, and as I said, I think if we are pouring billions of dollars into this industry, we ought to know who we are giving that money to.

Mr. WHITFIELD. One other question, Attorney General Blumenthal. As attorney general of Connecticut, do you have the authority yourself to close down a nursing home if it is providing substandard care?

Mr. BLUMENTHAL. I do not alone. I can act only when the experts—I am not a healthcare expert, I am not a doc, I am not a trained medical person nor is anyone on my staff. I depend on the Department of Social Services to go through a proceeding and that happened in this instance eventually and we did go to court, but I cannot unilaterally do so, but I want to come back—I think you have asked an excellent question, why do we care about ownership? Well, if you take the case that you just heard about, Oscar Aceituno suffered huge harm and that facility should have been held accountable, and it was not because it said we don't have resources. So they sent $1. If they had known who the owner was and been able to go after him and hold him accountable, he would not have been using those resources to buy a record company in

Tennessee or a house on the front of a lake. Now, that is an extreme example. The resources were there but the chain of command and control was so complex that it couldn't be held accountable.

Mr. WHITFIELD. Thank you, Mr. Chairman.

Mr. STUPAK. Let me just briefly follow up on that, if I may, and if anyone wants to jump in, go ahead. We only have a few minutes. We are going to break for votes. Even though you may know who the owner is and they may be out of State and you can follow the money, that still doesn't require or make certain that the nursing home is—that money is going into the nursing home. They have a right after they pay whatever they do, whatever money left over to use how they want. It doesn't necessarily guarantee an improvement for those residents. So other than your surety bond or your insurance proposal, minimum insurance liability proposal, how do you get them to do the right thing in this case? Because we pay $78 billion a year in direct costs. That is not counting all the other parts of Medicare which are doled out to nursing homes for therapy and drugs and other things.

Mr. BLUMENTHAL. Well, that question, which is an excellent one, goes to some of the other suggestions I have made. Information sharing would presumably alert a regulator in Illinois or Michigan or Vermont or New Hampshire about an individual in Connecticut who was betraying the public trust, and it is a trust. People are entrusted to the care of this institution, and if there were the kind of pattern of violations, citations, findings in Connecticut that were established there, it could be made available to others and eventually even in Connecticut, action could be taken against him.

Mr. STUPAK. So that minimal insurance policy, the more violations you have, should you tie bar it to that and make sure insurance liability then go up?

Mr. BLUMENTHAL. It could and should be raised, and if it applied uniformly across the country as a condition of Federal Medicare or Medicaid aid, it would be even more effective. But some of the proposals I have made have to do with greater cooperation among the States, which I think has to happen.

Mr. STUPAK. Sure. Mr. Morris, did you want to say something quickly and then I am going to go to Mr. Shimkus for a question.

Mr. MORRIS. Yes. Just to elaborate, that not only information sharing among States but actually information sharing with those in command and control. If we can establish that those who control the resources know of the substandard care being provided at the facility level, it increases accountability and may draw their attention to fixing those problems.

Mr. STUPAK. So as our ombudsman, he is our first line of defense in a way?

Mr. MORRIS. The ombudsman, but also going upstream in the corporation so you don't get the defense of, "I had no idea what was going on; you can't hold me personally accountable."

Mr. BLUMENTHAL. If I may——

Mr. SHIMKUS. We are really running out of time and I need to get this going.

Mr. STUPAK. Go ahead.

Mr. SHIMKUS. We have got 4 minutes to get to the floor for the vote. Because Mr. Weems is going to testify on the last panel. He states in his testimony, "Nursing homes are required to submit updates to their existing provider enrollment when they have a change in information, such as ownership, which then populates the PECOS database. Using PECOS, CMS has the ability to better track ownership and changes in ownership." Mr. Morris, do you want to respond to that?

Mr. MORRIS. As I believe I said earlier, the challenge is getting to multiple tiers of ownership. My understanding is, PECOS actually only addresses direct——

Mr. SHIMKUS. Does CMS have the authority? The question is legislation, or do they have already have the authority to force this?

Mr. MORRIS. I don't know the answer to that.

Mr. SHIMKUS. We need to find out that answer, Mr. Chairman.

Mr. STUPAK. OK. Thanks. We are going to excuse this panel. We may follow up with other written questions because I know I want a couple more questions, and we have five votes, and we are going to recess until 12:30, and I don't want to keep you here until 12:30 for a few more quick questions. So we will dismiss this panel. We will recess. We will back at 12:30 for our second panel.

Thank you all for being here. Mrs. Aceituno, thank you especially for your difficult testimony, and I thank each one of you for what you try to do to bring some enforcement to this industry.

[Recess.]

Mr. STUPAK. We are going to reconvene this hearing. I see our second panel. Is Mr. DeBruin here? Does anyone have any idea where he is at? I hate to go through and swear in the witnesses and have to do it again. Well, let us begin.

On the second panel, we have Dr. David Zimmerman, who is the Director of the Center for Health Systems Research and Analysis at the University of Wisconsin-Madison; Dr. Andrew Kramer, who is Professor of Medicine and Head of Colorado Division of Health Care at the University of Colorado; Mr. Neil Pruitt, Jr., who is the Chairman and CEO of the UHS-Pruitt Corporation, a large nursing home chain headquartered in Georgia; and Dr. Mary Jane Koren, who is Chair of the American Healthcare Association's Advancing Excellence campaign. And Mr. DeBruin, we will wait for you, who is a former nursing home worker and president of Pennsylvania Service Employees International Union.

As you know, it is the policy of this subcommittee to take all testimony under oath. Please be advised that witnesses have the right under the Rules of the House to be represented by counsel. Do any of you wish to be represented by counsel during your testimony? Everyone seems to be shaking their heads no. I will take it as a no. Therefore, I am going to ask to please rise, raise your right hand, and take the oath.

[Witnesses sworn.]

Mr. STUPAK. Let the record reflect that each witness answered in the affirmative. Therefore, you are under oath as you give your opening statement.

We will begin with you, Mr. DeBruin, for a 5-minute opening statement. If you have a longer statement, we will make it part of the record but we will go 5 minutes with your opening. If you

would begin, sir. Make sure that light is on and pull it fairly close so we can hear you.

STATEMENT OF THOMAS DEBRUIN, PRESIDENT, PENNSYLVANIA SERVICE EMPLOYEES INTERNATIONAL UNION

Mr. DEBRUIN. Chairman Stupak, Ranking Member Shimkus and honorable members of the subcommittee, I thank you for the opportunity to testify today. I am the president of SEIU Health Care Pennsylvania, and I am here today speaking on behalf of SEIU's 1.9 million members, including 150,000 nursing home workers.

Nearly 35 years ago, I began my working life as a nursing assistant in a large public nursing home. Even today, I can remember my first day on the job, the challenge of providing quality, compassionate care and support for the frail, elderly residents entrusted to me. I have seen a great deal of progress since that time but I am here today out of a great concern about our ability to continue that progress.

A new player has entered the nursing home world: private equity firms. SEIU is deeply concerned that the private equity business model, which seeks to make extreme profit, will operate at the expense of nursing home residents, their families, caregivers, and taxpayers. Buyout firms operate behind a veil of secrecy that allows them to conceal virtually all aspects of their business from regulators and affected stakeholders.

Others have testified today and at other congressional hearings about the tragedies that occur too often in nursing homes. These tragedies will only continue because Federal laws and regulations have failed to keep pace with the trends in nursing home ownership and financing, which are placing many homes in financial jeopardy while making it increasingly difficult to hold them accountable for patient care problems. The industry has moved towards increasingly complex corporate structures and highly leveraged buyouts. For example, last year, the Carlyle Group completed a $6.6 billion leveraged buyout of Manor Care. It remains unclear how Carlyle Manor Care will service such high debt without some effect on care. Plain common sense suggests that there is reason to be worried about cost-cutting pressure at a company that has just taken on almost $5.5 billion in new debt. Are we really to believe Carlyle's investment plan for Manor Care is to drive a profitable company deeply into the red and not cut costs, of which staffing is one of the largest, to keep its investment profitable?

There is a real concern that nursing homes involved in highly leveraged buyouts will cut staffing to pay off debt. This raises concern both about the safety of residents and about the value taxpayers are getting for Medicare and Medicaid dollars.

In addition to the concern of inadequate staffing, there is a fundamental lack of transparency in the nursing home industry. Nursing homes today employ ownership structures that obscure who is actually responsible for decisions that impact the quality of care in the facility. Buyout firms set up layered entities. Sometimes there are hundreds of entities involved to run their nursing homes and avoid liability, often separating the real estate asset holdings from the operations.

Such diffuse structures become even more complex when employed by large chains, which may create multiple layers of corporate shields that stand between the ultimate parent company and the facility-level LLCs. Nursing home chains have used such structures in the past to frustrate efforts by regulators to hold parent companies accountable for the care provided in their facilities and to obscure transactions and self-dealing between related parties. CMS has previously testified that they do not know who owns all nursing homes in this country. This despite the fact that the nursing home industry receives $75 billion a year from Medicare and Medicaid. How can Congress accept this?

Twenty years ago, it was at the urging of courageous reformers like Chairman Dingell and Pennsylvania's Republican Senator, the late John Heinz, that Congress passed landmark nursing home reform legislation. The real question before you is whether Congress will show the political courage today to once again pass significant nursing home reform. In February, Senators Grassley and Kohl introduced the bipartisan bill S. 2641, the Nursing Home Transparency and Improvement Act, and Representatives Stark and Schakowsky have indicated that they will introduce similar legislation soon.

Congress will likely pass a Medicare bill this year. The Senate is currently negotiating legislation which means there is an opportunity to attach S. 2641, a no-cost bill, and I invite the industry to work with us to pass S. 2641. We commend many in the industry who have recognized the need for greater transparency. However, the for-profit industry appears to be blocking this legislation. We stand ready to work with them, but if they choose to continue lobbying against this bill, then I urge Congress to stand up to the industry pressure and stand with the vulnerable seniors who count on their members of Congress to represent their interests. Hearings are not enough. Your constituents want to take real action and not simply talk about the problem.

Taxpayers trust that Medicare and Medicaid dollars will go toward providing seniors with quality care they deserve and will not become profit at the expense of nursing home residents. Congress must exercise its oversight authority to ensure that Medicare and Medicaid dollars are spent as intended, to provide high-quality care. We must not fail to protect our seniors and we cannot allow the bad actors in the for-profit nursing home industry to continue to let our seniors down and block attempts to pass meaningful reform. With S. 2641 and the Stark-Schakowsky bill soon to be introduced, you have a great opportunity before you and we urge you to seize it.

I thank you very much for inviting me here to testify.

[The prepared statement of Mr. DeBruin follows:]

Testimony of Thomas DeBruin

President
SEIU Healthcare Pennsylvania (District 1199P)
1500 N Second Street
Harrisburg, PA 17102

On "In the Hands of Strangers: Are Nursing Home Safeguards Working?"
Before the Oversight and Investigations Subcommittee
Committee on Energy and Commerce
U.S. House of Representatives
May 15, 2008

Chairman Stupak, Ranking Member Shimkus and honorable members of the Subcommittee, I thank you for the opportunity to testify before you today. I am the President of SEIU Healthcare Pennsylvania (District 1199P), the state's largest and fastest-growing union of health care workers, representing more than 22,000 employees in hospitals, nursing homes, home care, and state facilities. I am also an elected SEIU Vice-President and serve on our International Executive Board. I am here today speaking on behalf of SEIU's 1.9 million members, including 150,000 nursing home workers.

Nearly 35 years ago, I began my working life as a nursing assistant in a large public nursing home. Even today, I can remember my first day on the job, the challenge of providing quality, compassionate care and support for the frail elderly residents entrusted to me. Dealing with my own fears and emotions in order to stay focused on maintaining and enhancing their dignity and independence as I did my work. I remember the long shifts, weekends, mandatory overtime, and the constant back breaking lifting. But, most of all, I remember the people, the residents that I had the opportunity to meet and to work with, their personalities, their stories, their challenges, and their important medical and emotional victories and devastating defeats. I grew to love my work and the special people I worked with.

For the last 27 years I have worked hard to build my Union, to create a critical voice for long term care workers, and as a powerful advocate for improving the quality and standards of care for the elderly and frail that must rely on us in their times of need. I have worked with, and I have fought with large public "non-profit" authorities, important government agencies, and the nation's largest and most powerful "for profit" nursing home chains. I have seen a great deal of progress over that time. But, I am here today out of great concern about our ability to continue that progress.

A new player has entered the nursing home world--private equity firms. SEIU is deeply concerned that the private equity business model, which seeks to make extreme profit, will operate at the expense of nursing home residents, their families, caregivers, and taxpayers. Unlike publicly traded companies that are subject to federal securities laws and regulations as well as to daily scrutiny by financial analysts and the business media, private equity firms operate virtually free of oversight and public accountability, their profits and practices largely hidden from view. This lack of transparency is built into their business model, providing buyout firms with certain advantages that publicly traded companies do not enjoy. Buyout firms operate behind a veil of secrecy that allows them to conceal virtually all aspects of their business from regulators, affected stakeholders, the general public, and their competitors.

Others have testified today and at other Congressional hearings about the tragedies that occur too often in nursing homes. These tragedies will only continue because federal laws and regulations have failed to keep pace with trends in nursing home ownership and financing, which are placing

many homes in a financial jeopardy while making it increasingly difficult to hold them accountable for patient care problems. The industry has moved towards increasingly complex corporate structures and highly leveraged buyouts. For example, last winter, the Carlyle Group, one of the world's largest private equity buyout firms, completed a $6.6 billion leveraged buyout of HCR Manor Care, the nation's largest nursing home care provider. This buyout rightfully raised serious concerns for nursing home staff trying to provide quality care; for state surveyors whose job it is to provide ongoing oversight; for the taxpayers who fund the bulk of this care and; most importantly, for the residents who could suffer if Manor Care's billions in buyout debt affect quality of care. It remains unclear how Carlyle/Manor Care will service such high debt without some effect on care. Plain common sense suggests that there is reason to be worried about cost-cutting pressure at a company that has just taken on up to $5.5 billion in new debt. SEIU estimates that the new interest expense alone in just the first year after the Carlyle takeover could be up to $400 million. This figure, which does not even include the increase in principal payments, is already more than double Manor Care's entire profit of $167 million in 2006.[1] How will this massive new expense be paid for? Are we really to believe Carlyle's investment plan for Manor Care is to drive a profitable company deeply into the red, and not cut costs—of which staffing is one of the largest-- to keep its investment profitable?

A significant body of research suggests staffing levels are the best measure of quality of nursing home care and the GAO has reported that many nursing homes are understaffed. So there is a real concern that nursing homes involved in highly leveraged buyouts will further cut staffing to pay off debt—at the cost of resident care. This raises concern both about the safety of residents and about the value taxpayers are getting for Medicare and Medicaid dollars.

In addition to the concern of inadequate staffing, there is a fundamental lack of transparency in the nursing home industry. According to a September 23, 2007 New York Times expose, "Byzantine" structures such as those employed by private equity and large chains have frustrated the efforts of state regulators to hold long term care facilities accountable for the quality of care they provide. Nursing homes today employ ownership structures that obscure who is actually responsible for decisions that impact the quality of care in the facility. These buyout firms set up layered entities—sometimes there are hundreds of entities involved--to run their nursing homes and avoid liability, often separating the real estate asset holdings from the operations. A typical model may include one special purpose LLCs to hold a facility's license, another LLC to hold the real estate and tangible assets, and contracts with management companies to run the facility's day to day operations.

Such diffuse structures become even more complex when employed by large chains, which may create multiple layers of corporate shields that stand between the ultimate parent company and

[1] Manor Care's reported net income in 2006 was $167,084,000. Manor Care, Inc., Schedule 10-K for Fiscal Year ended 12/31/06, p. 45.

the facility-level LLCs. Nursing home chains have used such structures in the past to frustrate efforts by regulators and plaintiffs to hold parent companies accountable for the care provided in their facilities, and to obscure transactions and self-dealing between related parties. CMS has previously testified that they do not know who owns all nursing homes in this country. This despite the fact that the nursing home industry receives $75 billion a year from Medicare and Medicaid. How can Congress accept that we are paying Medicare and Medicaid dollars to homes where we don't know who is responsible?

Twenty years ago, it was at the urging of courageous reformers like Chairman Dingell and Pennsylvania's Republican Senator, the late John Heinz III, that Congress passed landmark nursing home reform legislation. The real question before you is whether Congress will show the political courage today to once again pass significant nursing home reform. In February, Senators Grassley and Kohl introduced the bipartisan bill, S2641, the Nursing Home Transparency & Improvement Act. And Representatives Stark and Schakowsky have indicated that they will introduce similar legislation soon.

This no-cost bill will increase transparency and promote accountability of nursing home owners and operators, particularly nursing home chains, by requiring companies to disclose fully the corporate entities that own nursing homes and the affiliated entities that operate them or have other financial or operational relationships. By requiring all nursing homes to report their nurse staffing levels and turnover and retention patterns and to clearly show how Medicare dollars are being spent, including expenditures for nursing staff, the bill will provide American families and policymakers critical information in evaluating the quality of care at the nation's nursing homes. Similarly, by creating a national independent monitor program to look closely at the performance of nursing home chains, the bill will make it easier for CMS to identify irresponsible corporations that operate in more than one state.

This bill has been endorsed by the AARP, the Alzheimer's Association, the National Association of State Long-Term Care Ombudsman Programs, and the Leadership Council of Aging Organizations. Congress will likely pass a Medicare bill this year—the Senate is currently negotiating legislation--which means there is an opportunity to attach S2641—a no-cost bill. I invite the industry to work with us to pass S2641 the Nursing Home Transparency & Improvement Act. We commend many in the industry who have recognized the need for greater transparency. However, the for-profit industry appears to be blocking this legislation. We stand ready to work with them. But if they choose to continue lobbying against this bill, then I urge Congress to stand up with us, and with the vulnerable seniors who count on their Members of Congress to represent THEIR interests. Hearings are not enough. Your constituents want you to take real action, and not simply talk about the problem.

Taxpayers trust that Medicare and Medicaid dollars will go toward providing seniors and the disabled with the quality care they deserve and will not become profit at the expense of nursing home residents, their families, caregivers, and taxpayers. Congress must exercise its oversight authority to ensure that Medicare and Medicaid dollars are spent as intended—to provide high quality care. We must not fail to protect our seniors and we cannot allow the bad actors in the for-profit nursing home industry to continue to let our seniors down and block attempts to pass meaningful reform. With S2641 and the Stark-Schakowsky bill soon to be introduced, you have a great opportunity before you and we urge you to seize it.

I thank you for inviting me here to testify.

Mr. STUPAK. Thank you, Mr. DeBruin.

Dr. Zimmerman, if you would, please, for your opening statement, sir.

STATEMENT OF DAVID ZIMMERMAN, PH.D., DIRECTOR, CENTER FOR HEALTH SYSTEMS RESEARCH AND ANALYSIS, UNIVERSITY OF WISCONSIN-MADISON

Dr. ZIMMERMAN. Good afternoon, Mr. Chairman. As a fellow UPR—that would be Dollar Bay, Michigan—I am especially pleased to be here this afternoon. My name is David Zimmerman. I am a professor of health systems engineering at the University of Wisconsin-Madison, and I am the director of the Center for Health Systems Research and analysis at UW Madison. I am also the president of the Long Term Care Institute, a nonprofit organization created to assist in the monitoring of quality of nursing home care in organizations with corporate integrity agreements with the Office of the Inspector General within the Department of Health and Human Services.

As researchers and monitors, our clinicians and analysts have conducted visits to more than 1,000 nursing homes in the past 8 years. We have observed or participated in more than 100 quality improvement meetings, including more than 30 such sessions at the corporate level of organizations. I have spoken to at least 15 corporate boards or board committees and met with individual board members about quality of care issues. So we have been observing and analyzing the care of nursing home residents and the systems that govern this care from the bedside to the boardroom.

What are some of the things we have learned from this rich field experience? One thing that is very clear from our experience is that there is tremendous variation in the quality of care by facility, by unit and area of care within a facility, by district and region and across nursing home corporations as a whole. Even the best performing organizations have pockets of mediocrity in performance, and even in the worst performing organizations, there are facilities that deliver good care. It is this inconsistency that represents one of the most difficult challenges to overcome, and yet it also represents a significant opportunity to take a systems approach to improving nursing home quality of care.

Frankly, another thing that comes out loud and clear from our field experience is that there is an unarguable need for transparency in the provision of nursing home care. Others have spoken to this issue, and frankly, I am astonished that it still is even a subject of debate.

What else have we learned? Well, we have some pretty solid preliminary evidence that monitoring has had a positive impact on improvement in regulatory outcomes, at least for the national and regional corporations that have been the subject of our work and our analysis. The initial findings are also quite positive in terms of the effect of monitoring on reducing excessive rates of resident functional and clinical impairment. In addition, we have substantial anecdotal evidence, including feedback from the providers themselves, that monitoring has had a productive impact on their quality assurance and quality improvement initiatives.

How does monitoring help? We believe the presence of monitors and monitoring activities has elevated the importance of the internal compliance function within the organization themselves and it is difficult to exaggerate the importance of this. Having a more important and a more prominent compliance function within the facility and the organization not only improves the quality of care but imbues the organization with an enhanced culture of quality by making compliance a more visible and integral part of the leadership and management of the organization. Our experience has been that this increased presence and visibility as well as the existence of a more direct line of communication between compliance and top leadership including the board can lead directly to improved care and it can help put quality of care on an equal footing with financial stewardship within the organization.

Another advantage of the monitoring process is it can help to expand the quality assurance function beyond individual facilities to levels of organization that can more effectively make things happen to implement quality initiatives and help to sustain them throughout the organization.

Another important contribution, and one which we stress greatly in all of our work, is the emphasis on systems of care and quality assurance at all levels of the organization. Probably the single most important insight from our monitoring work has been the importance of developing and sustaining effective systems of care which along with good policies and procedures can promote more consistent care across units, facilities, districts and regions of organizations. Too often we find that such consistency is lacking and it was through continuous interaction with the organization including at the top levels that this commitment to consistency and capability to bring about consistency was achieved.

A critical corollary point is that implementing and sustaining good systems of care and quality assurance demands loyalty to what we have come to refer to as the V word, validation. Too many times we have found that those responsible for the oversight of quality in monitored organizations would accept without validation assurances of compliance with policy or that care protocols were being carried out as documented or reported yet validation did not confirm that this was true. When quality assurance efforts include validation, that what was said was happening was indeed happening consistently, then care improved markedly. Validation must be a fundamental part of any effective quality oversight function or any quality initiative that the industry or the regulatory community undertakes. This of course includes validation of staffing levels and staff competencies.

So in conclusion, we believe that the internal compliance function is absolutely essential to meaningful quality improvement and quality assurance. It can work side by side with the regulatory community to bring about lasting quality of care for nursing home residents.

Thank you.

[The prepared statement of Mr. Zimmerman follows:]

Testimony of David R. Zimmerman, Ph.D.

Professor, Department of Industrial and Systems Engineering
Director, Center for Health Systems Research and Analysis

University of Wisconsin–Madison

House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations Hearing
May 15, 2008

Good Morning.

My name is David Zimmerman. I am a Professor of Health Systems Engineering in the Department of Industrial and Systems Engineering at the University of Wisconsin-Madison, and I am the Director of the Center for Health Systems Research and Analysis at UW-Madison. I am also the President of the Long Term Care Institute, a non-profit organization created to assist in the monitoring of quality of nursing home care in organizations with Corporate Integrity Agreements with Office of the Inspector General within the Department of Health and Human Services.

I have been conducting research in nursing home quality of care and performance measurement for more than 25 years. For more than a decade researchers at our Center have been involved in projects funded by the Center for Medicare and Medicaid Services (CMS) to improve the quality assurance process. We also developed the original set of quality indicators—now called the "Quality Indicators/Quality Measures"—based on a standardized nursing home resident assessment instrument referred to as the Minimum Data Set. More recently at the Long Term Care Institute, we have been involved in more than 15 nursing home monitoring engagements with national and regional nursing home corporations, covering more than 1000 nursing homes and 100,000 nursing home residents. We have done this monitoring work as part of our involvement in the aforementioned corporate integrity agreements between nursing home organizations and the DHHS Office of the Inspector General.

As researchers and monitors, our clinicians and systems analysts have conducted visits to more than 1000 nursing homes in the past eight years. We have observed or participated in more than 100 quality improvement meetings, including more than 30 such sessions at the corporate

level of organizations. I have spoken to at least 15 corporate boards or board committees and met with individual board members about quality of care issues. So we have been observing and analyzing the care of nursing home residents—and the systems that govern this care—from the bedside to the boardroom. This experience has given us important insights into the world of quality assurance and quality improvement in nursing homes and the corporations that own some of them.

If there is one thing that is very clear from our monitoring experience it is that there is tremendous variation in the quality of care by facility, by unit and area of care within a facility, by district and region, and across nursing home corporations as a whole. Significantly, even the best performing organizations have pockets of mediocrity in performance, while at the other end of the spectrum, even in the worst performing organizations there are promising signs of good care. It is this inconsistency that, while probably not surprising, represents one of the most difficult challenges to overcome and yet also represents a significant opportunity to take a "systems" approach to improving nursing home quality of care. There are other significant and common inferences that we can draw from our monitoring experience and I address these inferences in the remainder of my remarks. What have we learned from this rich experience, can help make some sense of the variety of legislative proposals that are currently under consideration in both Houses of Congress.

Transparency on Ownership and Care Providers

I noted in previous testimony six months ago, to the Senate Select Committee on Aging, that there has been increasing attention on the quality of nursing home care because of the rise in the number of ownership transactions between regional and large nursing home corporations, including ownership transfers from a public corporation to entities commonly referred to as private equity firms. I noted at that time that the issue at the heart of this debate was not necessarily private equity ownership, but rather **transparency**. Nothing I have seen in the past six months has changed my position on this matter.

It is still undeniable that the purchaser and recipient of nursing home care have the right to know who is providing that care. When that purchaser is the federal government, which spends billions of dollars on nursing home care every year, the case for complete transparency is compelling. There are two levels of transparency that should be required:

1. Who owns the entities that are responsible for the provision of care?
2. What (or at least how many) individuals are providing the care?

The propositions with respect to ownership transparency are simple:

- The federal government should have the right to know, with complete transparency, the complete ownership structure of every nursing home participating in the Medicare and Medicaid program, including any entity with which the owners of the nursing home contract to provide care. Ownership information should also be provided on any owner(s) of the "bricks and mortar assets," that is the physical structure and associated property, including information about all contract provisions pertaining to the lease arrangements.
- It is the responsibility of the care provider organization to "produce" this transparency. That is, it is the obligation of the entity providing the care for which they are reimbursed, and not the purchaser of care, to make sure that full and complete information about the ownership of all entities responsible for care decisions is available. The complete ownership structure of all entities involved in the provision and administration of resident care should be fully available to CMS, either through routine reporting or through unambiguous, immediate, and completely forthcoming submission and explanation of the material upon request.
- The principle of transparency should apply no matter what level of complexity in the labyrinth of organizational structures exists. The more complex the web, the greater the need for more detailed transparency. And, the greater the complexity, the more reasonable it is that the originator of that complexity ought to have the responsibility for explaining it to the purchaser of care.

With respect to information about who provides the actual care, the principles are equally simple:

- Nursing home owners should report the staff resources, on a resident-time basis, that are devoted to resident care—not just once a year as currently but on a routine basis.
- This information should be based on payroll data, which exist in accessible form for virtually every nursing home in the country.
- The technological means exist to submit and receive staffing data, in a standardized format, for the entire nursing home industry. Reasonable people representing all stakeholders can make sound decisions about how to structure the definitions into a

common taxonomy. Acuity-based staffing, which is to date far less common in practice than in pronouncement, can be taken into account if necessary.

Compliance, Corporate Integrity Agreements, and Independent Monitoring

We have learned a great deal about monitoring nursing homes, as well as the corporate integrity agreements under which monitoring engagements operate and the corporate compliance functions which are a major focus of those monitoring efforts. First, we have some pretty solid preliminary evidence that monitoring has had a positive impact on improvement in regulatory outcomes, at least for the national and regional corporations. Our preliminary analysis suggests that monitoring and corporate integrity agreements that include monitoring provisions have improved the survey performance of the monitored organizations, in terms of lowering the number of deficiencies and, given that, the likelihood of what we call "severe deficiencies." It is difficult, of course, to tease out the impact of monitoring from other trends in survey deficiencies over that same time period, but our initial efforts to utilize statistical models to control for those other trends suggest that there has been a positive, net impact of monitoring. I caution that we are still working on these analyses, as well as further analysis to determine whether monitoring has had an impact on resident clinical and functional status. We have made a firm commitment to having an independent source review the methodology and results of our work; we are presently making arrangements for that review. That caveat noted, the initial findings are quite positive. In addition, we have substantial anecdotal evidence, including feedback from the providers themselves, that monitoring has had a productive impact on their quality assurance and quality improvement initiatives.

What advantages does the monitoring of internal compliance and quality assurance programs bring to the table? We believe the presence of monitors and the monitoring activities have elevated the importance of the internal compliance function within the organizations themselves. Having a more important and a more prominent compliance function within the facility, we believe, not only improves the quality of care, but also imbues within the organization an enhanced "culture of quality" by making compliance a more visible and integral part of the leadership and management of the organization. Our experience has been that this increased presence and visibility, as well as the existence of a more direct line of communication between compliance and top leadership—including the board—has an effect beyond just

increasing specific quality improvement initiatives. It can help put "quality of care" on an equal footing with financial stewardship within the organization.

Another advantage of the monitoring presence is that it can help to expand the quality assurance function beyond individual facilities to levels of the organization that can more effectively "make things happen" to implement quality initiatives, and help to sustain them, throughout the organization. This ability to observe and assess, as well as impact, quality assurance throughout the organization is one most difficult challenges for the current regulatory process. We must have a way of aggregating accountability and responsibility for quality assurance above the individual facility to higher levels in the organization.

Yet another important contribution of the monitoring process, we believe, is its emphasis on the ***systems*** of care and quality assurance at all levels of the organization. One of our most important insights from our monitoring work has been the importance of developing and sustaining effective systems of care, which—along with good policies and procedures—can promote more consistent care, across units, facilities, and districts and regions of organizations. Often times we found that good care was evident in particular facilities, or units within facilities, but consistency was missing so that effective care practices were too "hit or miss." Presumably one of the expected benefits of having a network of facilities is that consistency in care systems, practices, and policies, can be ensured. But too often we found that such consistency was lacking, and it was through continuous interaction with the organization, including at the top levels, that this commitment to consistency and capability to bring about consistency was achieved.

A critical corollary point is that implementing and sustaining good systems of care—and quality assurance—demands loyalty to what we have come to refer to as the "V-word: ***validation***." Too many times we found that those responsible for the oversight of quality in monitored organizations would accept without validation assurances of compliance with policy or that care protocols were being carried out as documented or reported; yet validation did not confirm that this was true. When quality assurance efforts included validating "that what was said was happening, was indeed happening"—consistently rather than occasionally—then care quality improved markedly. Validation—of policies and care practices, at the most granular level—must be a fundamental part of any effective quality oversight function.

This validation must include a focus on staffing levels and staff competencies, as well. Validation of staffing levels through crosswalks of schedules and payroll information, combined with occasional spot-checks of the number of staff on facility units, is critical to the credibility of stated staffing levels. Staff competency is becoming one of the most important requirements in nursing home care, especially with the increasing complexity of the post-acute care population we now observe in the nursing home setting. Nursing home leaders acknowledge that the lack of adequate competency is one of their most serious problems, and one of the sources of greatest provider risk, that they face in today's environment.

Along with this increased emphasis on competency, there must be a firm, unalterable commitment to not admitting residents if a nursing home does not have sufficient, competent staff or equipment and other necessary resources to meet the needs of residents. This calls, in turn, for a clear commitment to the dominance of clinical considerations over marketing in the admission decisions made at the nursing home and corporate level. There is no doubt about the real and difficult challenges the current environment places on nursing homes; but there can be no compromise on the principle that clinical considerations must be the deciding factor in whether to admit a resident.

Conclusion and Suggestions

There is a common thread running through these insights that we have gained in the course of our monitoring work. It starts with the simple principle that if we are going to see meaningful improvement in the quality of nursing home care, the provider community has to step up to the plate and meet its responsibility to build and sustain strong internal systems of compliance and quality assurance. This is not to say that a strong regulatory presence has outlived its usefulness; quite the contrary, a strong enforcement program is essential, both because those in need of protection represent the most vulnerable population in our society, and because the level of commitment and capability within the industry is not sufficient to instill confidence that quality can be assured without external scrutiny and regulation.

We believe that there are some hopeful signs on the horizon to improve the functioning of the regulatory process. For example, the recent "focused facility" initiative on the part of CMS can help to more effectively triage problematic facilities and organizations, which will help allocate scarce regulatory resources more efficiently to those problem entities in greater need of

closer scrutiny. We have several suggestions to improve the functionality of the "focused facility" project. One recommendation is to increase the consistency of the program in terms of the criteria on which facilities and organizations are selected. Another recommendation is to ensure that there is more consistency across the country in the specific protocols that are used to bring the focused facilities into compliance, as well as the protocols used by the oversight agency to confirm that the stated remedial actions are taking place.

We also believe that the "focused facility" initiative can provide a good testing ground for some of the concepts I suggest in my testimony. In this regard we endorse the suggestions made by Lew Morris on behalf of the OIG's office; the focused facility project would be an excellent place to test some of these suggestions.

Effective internal compliance programs are an essential component of meaningful quality assurance in our nursing homes. There can be no substitute for transparency in this care setting, and transparency necessitates greater internal accountability and compliance in nursing home organizations. More effective internal compliance, in turn, means that nursing home organizations must be prepared to validate that:

- All levels of the organization are capable of consistently implementing and sustaining policies, protocols, and systems that promote and assure high quality resident care
- All levels of the organization can ensure sufficient and competent staff to deliver that care; and
- All levels of the organization can monitor and oversee standardized care systems of meet individual resident needs.

For nursing home organizations that have not demonstrated this internal compliance capability, outside monitoring resources should be available to provide external review and validate the commitment and capability of the organization, and to assist them in strengthening this internal compliance function. In an environment of increasing demand for services to an extremely vulnerable population, we must rely on both internal provider compliance functions and external oversight to ensure that compliance is present.

One final note is in order. As a nation, we have, necessarily, focused a good deal of attention on the nursing home setting in our efforts to ensure that our vulnerable elderly citizens get the care they deserve and need. If we are to truly accomplish the goal of giving those citizens the care they so richly deserve, then we need to expand our focus to include the other care

provider settings that feed into skilled nursing facilities. In particular, this must include greater scrutiny of acute care hospitals, whose discharge practices have placed enormous pressure on skilled nursing facilities, and who themselves are often inadequately prepared to provide the complex care needed by elderly patients with functional impairments in addition to the usual medical co-morbidities common to the usual hospital patient population. It also means that we must turn our attention to home care and the plethora of community-based programs that provide services to the elderly in far more diffuse and less-scrutinized settings.

This concludes my remarks.

Mr. STUPAK. Thank you, and everything is fine in Dollar Bay.

Dr. Kramer, your opening, please, sir.

STATEMENT OF ANDREW KRAMER, M.D., HEAD, PROFESSOR OF MEDICINE, DIVISION OF HEALTH CARE POLICY AND RESEARCH, UNIVERSITY OF COLORADO-DENVER

Dr. KRAMER. Good afternoon, Mr. Chairman, Mr. Shimkus, members of the Committee. I am a physician and a professor of medicine and health policy, and about 10 years ago I was over at the Hart Building and gave testimony similar to this before the Senate Special Committee on Aging. Chairman Grassley asked me, how come the methods I use in research are not currently being used in the survey process, because I had testified about problems with subjectivity and inconsistency in the survey process. My response was that I didn't know. And then in 1998 they began the QIS initiative, starting with a development contract. Dr. Zimmerman and I led the team on that early development of QIS.

So 10 years later, where are we? Well, we still have very good nursing homes out there, we have not so good ones, and we have poor ones. And the problem is that today you still can't tell from the information that is publicly reported or the information in the survey process which nursing homes fall in which categories. You can't tell. You know, I can't even tell from the information that is available. And that is a serious problem. We have enforcement problems because we don't have a system that surveyors are confident about, which my team has shown in some recent case study work. And we don't even have a national standard that is widely recognized, indicating what is quality for providers. But we are making some progress and we are making some progress in six States that have now implemented the Quality Indicator Survey. And I want to tell you a little bit about that progress we have made because I think it is very important for today's discussion. CMS is moving toward a national rollout of QIS, but it is very, very slow.

So the QIS, how is it different from the traditional survey? The QIS involves much larger samples of residents and facilities, people who are currently residing in the facility and recent admissions. And as somebody said earlier, in the QIS survey you talk to the residents. You talk to 40 of them. You ask them questions. You ask them, do you have choice about when you get up in the morning. You ask them whether they have oral pain. You find out about their nutrition. You ask them all sorts of questions. You make structured observations. You pull information from records. You pull weights out of charts. You ask them if they are on a weight-loss program. There are 162 indicators that are used in the first 2 days of QIS that cover the Code of Regulations. And that is what the QIS is based on: the regulations.

There is another aspect of the process very exciting: the data. It is very structured and very data driven and so at the end you can audit what surveyors are doing with all that information. In June we are actually training the regional office oversight people to use that same information in their oversight process.

So let us talk for a minute about what the impacts of QIS have been. First of all, the surveys. There have been over 700 surveys

that are QIS. There are over 200 surveyors trained in QIS. Of these the surveyors, 80-plus percent of them said they would never go back to the traditional process. Now, there are those that don't like this imposed structure. Deficiencies—we are finding deficiencies that are in the Code of Regulations that were never identified before. These deficiencies are in dental health and oral pain, because surveyors ask people about oral pain. There are programs in a couple of the QIS states that are being led by the Provider associations, working with the State Dental Associations, to start providing oral healthcare inside nursing facilities. Hospitalization, quality of life, and choices are the kinds of problems cited in QIS. The culture change movement has embraced QIS because of the importance of these areas.

There is another impact, consistency. When I first went to one of these QIS States, a group of providers came up to me and they said Dr. Kramer, we are getting a large increase in deficiencies in our district office. Guess what? This was a district office that had a long history of low deficiencies because the process was not consistent.

There has been one more impact of QIS and that is on providers. Providers have started to embrace and use the tools of QIS for quality improvement. Some are proactive whereas others receive a bad QIS survey, and then they use the tools for quality improvement.

And so the next question is, why has it taken 10 years to roll QIS out in six States? First of all, development. Development took many years. We had to build new systems under CMS contract to support QIS, so there was a great deal of development work. There was an evaluation that took twice as long as was expected, and that slowed things down. Secondly, everybody criticizes the survey process, but there is reluctance to change it. There is reluctance and we have worked together. At this stage there is a core group in CMS of about eight people that are very strong advocates of QIS, but it has taken some time.

And then the final issue is budget. Thirteen States applied to be QIS states after the demonstration. One of them was chosen, Minnesota. For the other States, CMS did not have budget to roll it out. And that has been the biggest problem, the budget has been uncertain. The budget commitment has been uncertain. It would take $20 million, one time, to roll QIS out in every one of the other States over the next several years, and that is the one recommendation I have to make.

Thank you.

[The prepared statement of Dr. Kramer follows:]

"In the Hands of Strangers: Are Nursing Home Safeguards Working?"
Summary of Testimony of Andrew M Kramer, MD

Ten years ago I provided testimony at a similar hearing before the Senate Special Committee on Aging where I identified major problems with the survey process related to consistency and ability to detect deficient practice in areas of critical importance to residents. The comments of the committee led to a bold initiative to modify the survey process using the same scientific methods that I used in my research, leading to the Quality Indicator Survey (QIS).

So ten years later, where are we? We still have very good nursing homes, good nursing homes, not so good nursing homes, and poor nursing homes. We still do not have a national nursing home survey process or consumer reporting system that consistently identifies which of these categories a nursing home is in. We continue to struggle with enforcement in part because of our inability to identify poor performers with confidence. And we have not provided a national measurable quality standard that all nursing facilities can strive to meet.

But we are making substantial process in the six states where QIS is being rolled out (CT, FL, KS, LA, MN, and OH). In these states, we have found that: 1) Most surveyors prefer QIS (e.g. "the QIS survey provides for a more consistent survey that is reproducible."); 2) issues of extreme importance to residents are being cited in QIS that were only rarely identified in the traditional survey process (e.g. choices, dignity, dental care, nurse staffing, nutrition) making it a more resident-centered survey process; 3) survey consistency is improved in the QIS states, with deficient practice identified more in some survey district offices that had an extended history of very few deficiencies on most surveys; 4) providers and provider associations are using the QIS tools for quality improvement and training; 5) providers claim that "computers kept surveyor attention focused on care and care related issues;" and 6) state agency managers, regional office evaluators, and CMS central office can use the data obtained on the computer throughout the QIS process to monitor and improve surveyor consistency.

For several reasons it has taken a full decade to accomplish this. First, developing and testing a consistent assessment approach spanning the full federal code of regulations, a rigorous training method, and the necessary software was a difficult task. Second, although many state surveyors, providers, resident advocates, CMS central office staff, and researchers are critical of the traditional survey process, many were initially reluctant to support large-scale change. Currently, there is a highly committed CMS team working on QIS. Third, budget uncertainty and the amount of funding allocated to QIS has resulted in numerous state agencies applying to be trained in QIS and even purchasing hardware in their state budgets, and then being told to wait until CMS has the funds to train them. At the current rate of 3 new states per year, it will take about 15 more years to roll out QIS nationally and even that may not happen unless there is a funding commitment so that survey agencies and states can prepare for training and purchase hardware. With the commitment of an additional $20 million, training could be completed in the other states and the infrastructure development could be finished in less than five years.

Given what has occurred in the states that have implemented QIS, nothing on the horizon would have a bigger impact on safeguarding the lives of nursing home residents and improving their quality of life than to fund the final refinement and implementation of QIS in the remaining states.

"In the Hands of Strangers: Are Nursing Home Safeguards Working?"

Testimony of Andrew M Kramer, MD, Professor of Medicine, University of Colorado

May 15, 2008

Ten years ago, I provided testimony for a similar hearing before the Senate Special Committee of Aging entitled, "Betrayal: The Quality of Care in California Nursing Homes." I had just assisted the GAO in a study of the nursing home survey process using a rigorous, resident-centered assessment approach for evaluating the quality of care and quality of life of residents in nursing homes.[1] In that study and hearing, I demonstrated major problems with consistency, ability to detect deficient practice, and resident-centeredness of the survey process.[2]

After learning about the process that my research team used to measure quality for nursing home residents, Committee Chair Senator Grassley asked me a series of questions about whether the process that we had developed could be used by state surveyors to conduct the survey, to which I indicated that it could, and we discussed the development that would be needed, some of the strengths of the approach for the survey, and the resources that would be required to train surveyors because the process is very different from the current survey process although it is based on the same code of regulations.[3] The development, testing, and implementation of this

[1] General Accounting Office. California nursing homes: care problems persist despite federal and state oversight. Report to the Special Committee on Aging, U.S. Senate. Report number: GAO/HEHS-98-202, 1998. Washington DC.

[2] A. M. Kramer. "Betrayal: The Quality of Care in California Nursing Homes". Special Committee on Aging, United States Senate :One Hundred Fifth Congress, Second Session. Serial Number. 105-30, 1998, page 139. Washington DC.

[3] A. M. Kramer. "Betrayal: The Quality of Care in California Nursing Homes". Special Committee on Aging, United States Senate :One Hundred Fifth Congress, Second Session. Serial Number. 105-30, 1998, page 204. Washington DC.

revised survey process, called the Quality Indicator Survey (QIS), became part of the Nursing Home Initiative in CMS and a contract to develop it was funded in fall 1998.[4]

So ten years later, where are we?

We still have very good nursing homes, good nursing homes, not so good nursing homes, and poor nursing homes. We still do not have a national nursing home survey process or consumer reporting system that consistently identifies which of these categories that a nursing home is in. We have continued to struggle with enforcement in part because of our inability to identify poor performers with confidence.[5] And we have not provided a national measureable quality standard that all nursing facilities can strive to meet.

But, we are making substantial progress in the six states where QIS is being rolled out (CT, FL, KS, LA, MN, and OH). Following the QIS development contract, in 2005 CMS funded a demonstration of the QIS in five states with two survey teams per state in CT, OH, KS, LA, and CA followed by a statewide training demonstration in FL beginning in 2007. At this stage, statewide roll out is underway in five of these states, one new state has been trained (MN), and three more are scheduled for training next year (NC, NM, WV). We found dramatic results in these states where QIS is implemented with over 700 surveys of record to date.

[4] A.M.Kramer, D. Zimmerman. "Evaluating the Use of Quality Indicators in the Long-Term Care Survey Process: Final Report. RTI international. 2005. North Carolina.

[5] H. Louwe, C. Parry, A. Kramer, and M. Feuerberg. Improving Nursing Home Enforcement: Findings from Enforcement Studies. Denver, CO: University of Colorado, Division of Health Care Policy and Research. 2007.

Many differences exist between QIS and the traditional survey process. First, in QIS, the surveyors select larger and statistically valid samples of residents to review during the survey. The surveyors use tablet computers to randomly select 40 current residents of the facility and 30 residents admitted in the last six months all of whom will be investigated in the first two days of the survey. In the traditional survey, a much smaller sample of residents is chosen through a combination of reviewing MDS results, survey history, touring the facility in a process that varies from state to state and surveyor to surveyor. In fact there is an industry built around helping nursing homes try to predict which residents will appear in the survey sample because it can influence your survey results so much.

Second, the care received by every one of the residents in the QIS sample is assessed on site through a combination of resident, family and staff interviews, resident observations, and chart reviews that are highly structured and replicable. These assessments are based on the code of federal regulations and include issues of great concern to residents. For example, some of the resident interview questions include:[6]

- Do you participate in choosing when to get up?
- Do you have tooth problems, gum problems, mouth sores, or denture problems?
- Do you have mouth/facial pain with no relief?
- Does staff help you as necessary to clean your teeth?
- Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time?

[6] "Quality Indicator Survey Resource Manual" found at http://www.uchsc.edu/hcpr/qis_manual.php

- Do you feel the staff treats you with respect and dignity? For example, does staff take the time to listen to you and are staff helpful when you request assistance?
- Do you receive assistance for things you like to do, such as supplies, batteries, books? (Facility should have items available for residents to use).
- Are there activities offered on the weekends, including religious events?
- Are there activities available in the evenings?

Every question requires a clear yes or no response, in contrast to the traditional process, where conversational interviews are conducted during which the surveyors are suppose to elicit residents concerns in all the regulatory areas, and yes they all do it differently and on much smaller numbers of residents.

Structured resident observations are made to such as these related to personal care:[7]

1) **Based on general observations, did you see any of the following?** (Mark all that apply)

a. Unpleasant body odor (other than signs of incontinence)
b. Skin is unclean (i.e., food on face & hands)
c. Eyes are matted
d. Mouth contains debris, or teeth/dentures not brushed, or mouth odor, or dentures not in place
e. Teeth broken/loose, or inflamed/bleeding gums, or problems with dentures
f. Hair is uncombed and not clean
g. Facial hair not removed or unshaven

[7] "Quality Indicator Survey Resource Manual" found at http://www.uchsc.edu/hcpr/qis_manual.php

h. Fingernails are unclean and untrimmed

i. Clothing and/or linens are soiled (other than signs of incontinence)

j. Glasses are dirty or broken

k. None of the above

Comments:

For weight loss, actual weights are recorded from the record for both long-term residents and new admissions and then weight loss is calculated, with exclusions for residents on weight loss programs and receiving terminal care.[8] In the traditional survey, the decision to investigate weight loss is based on an MDS item where the facility reports whether a resident has lost 5% or more of their weight in 30 days or 10 % or more in the last180 days.

Third, following preliminary investigation, rates of occurrence of 162 care issues spanning the regulations are determined. In-depth investigations then proceed in areas where the facility exceeds statistically derived thresholds that suggest areas where deficient practice may result. If very few areas trigger, then fewer survey resources are expended in that facility because they do not have as many quality of care and life concerns. If many areas trigger, well let's just say it is going to be a long survey. Even this in-depth investigation is structured by protocols that surveyors follow and respond to specific guidance in a structured format. The documentation collected on the tablet pc throughout the process is then uploaded into the statement of deficiencies.

[8] Ibid

Fourth, state survey agency managers, regional office evaluators conducting federal oversight, and CMS central office can use the data generated through this structured process to monitor consistency and rigor of the survey process. Desk audit reports are generated based on QIS surveys that yield information on variation in survey practices between states, district offices, survey teams and even surveyors. These results have been provided to survey agency managers and used by them to determine the sources of inconsistency and introduce corrective action. Regional Office surveyors from five of the ten regions who have been trained in QIS will be trained in June to use this same information to target federal oversight activities. CMS central office is beginning a survey consistency initiative based on this information. Unfortunately, the same type of information cannot be generated on the traditional surveys because the structure does not exist; something that many of the survey agencies doing QIS surveys have requested.

So what have we learned in the QIS implementation?

First, we learned that a large majority of surveyors prefer QIS and never want to return to the traditional process once they become proficient in QIS.[9] But it does take a full month to train a surveyor in the QIS process in order to ensure that they are complying with it. Following are several of the many favorable comments from surveyors,[10] but you should talk to survey agency directors and surveyors in any of the states that are implementing QIS to confirm these comments.

[9] A. M. Kramer. "Quality Indicator Survey Demonstration: The Big Picture", Chapter 8 in Evaluation of the Quality Indicator Survey (QIS), Final Report for Contract #500-00-0032, TO#7. Cambridge, MA: Abt Associates Inc. 2007.

[10] Comments from Connecticut surveyors or from the written survey of the first 52 registered QIS surveyors.

"I like the fact that I can talk to more residents. I can sit down on a one on one. I like the fact that it is more focused and that it is looking at other areas other than nursing and care issues.

"Before I used to write a lot of quality of care tags, but now I have included quality of life tags because of the way it is structured. You look at the whole facet of that person's life in the nursing home, which includes activities, which includes social services, finance, a lot more."

"The increased resident interviews give a broader picture of what the residents are experiencing in the home and what problems or concerns they have."

"Overall I think the QIS survey provides for a more consistent survey that is reproducible. More information about residents and the facility is obtained. I feel the QIS identified the problems and gives structured pathways to investigate areas."

"I think it is very objective, more than subjective. It directs you to the correct tag you need to use or gives you several tags that you can choose from. Still using your surveyor judgment, but it narrows the tags rather than sometimes you're not sure what tag to use."

Second, we learned that many issues of extreme importance to residents are being cited in QIS that were less frequently identified in the traditional process.

Non-compliance with a number of regulations related to quality of life and resident rights has been identified more frequently in QIS, such as:

F159 Facility Management of Resident Funds

F157 Inform of Accidents/Significant Changes, Transfer

F156 Inform Residents of Services/Charges/Legal Rights

F463 Resident Call System

F248 Activity Program Meets Individual Needs

F242 Self-Determination - Resident Makes Choices

F247 Notice Before Room/Roommate Change

F241 Dignity

A number of important quality of care issues have been identified more in QIS surveys, such as:

F272 Comprehensive Assessments

F329 Drug Regimen is Free from Unnecessary Drugs

F279 Develop Comprehensive Care Plans

F281 Services Provided Meet Professional Standards

F324 Supervision/Devices to Prevent Accidents

F429 Pharmacist Reports Irregularities

F325 Resident Maintain Nutritional Status Unless Unavoidable

Several areas related to personal care and functional well-being are cited more under QIS:

F309 Provide Necessary Care for Highest Practicable Well Being

F312 ADL Care Provided for Dependent Residents

F318 Range of Motion Treatment & Services

Concerns about oral health are identified more under QIS because of the direct questioning in this area. This has led to more dental services citations (F411 and F412) and in some states, like FL and KS, greater opportunities for both training and provision of dental services in long-term care facilities are now available. And as we would expect, direct questioning about staffing has led to more frequent identification of nurse staffing problems (F356).

Third, we found that there are more deficiencies in QIS than the traditional process on average, but 40% of facilities have the same number or fewer citations and 60% have more. In fact, in some survey district offices where they had a history of relatively few deficiencies, under QIS there were large increases in many of the facilities because the process was more consistent. We found zero deficiency facilities under QIS in every state, often in facilities that embrace the principles of culture change, the movement that is very attuned to the quality of life issues that surface in a QIS survey.

Fourth, providers although initially skeptical about QIS, are finding that they can use the tools year round for ongoing quality improvement to ensure that they are meeting the needs of their residents and if they do, they can improve care and have better survey results. They have also learned that the improvements required under QIS cannot be made within their survey window

and certainly not during the survey. Even with more deficiencies on average, many providers have come out in support of QIS once they learn about it and experience it. Marty Goetz, the CEO of River Garden Hebrew Home for the Aged, had this to say about QIS in a letter to Polly Weaver, Chief of Field Operations at the survey agency in FL:

> "Prior to our recent experience we were especially apprehensive around QIS and the effects that it would have upon our Home and its culture of care. Many of us (including me) were initially concerned that too much reliance was being placed on the application of complex algorithms and technology; and the purpose of the on-site visit would be lost as professionals were being diverted to "managing their computers." We were mistaken. Our experience was that the notebook computers kept surveyor attention focused on care and care related issues. Surveyors used their computers as interactive tools in driving the survey, but at no time did it appear that professional decision-making had been relegated to computers."[11]
>
> He went on to many other statements such as: "The QIS process and structure keeps everyone's attention focused and doesn't easily allow for "survey drift" (my term)."

As you know, this is a rare response to a regulatory process that is basically punitive. Favorable responses have been also been obtained from for-profit providers, such as: [12]

[11] Quote from letter from Martin A. Goetz, Chief Executive Officer, River Garden Hebrew Home/Wolfson Health and Aging Center, Jacksonville, Florida.

[12] Quote from for-profit providers in Connecticut surveyed under QIS

"As the provider, we view the QIS survey as a more consistent and systematic process."

"The questions were good, and I just really liked the objectivity. I've had some uncomfortable experiences in the past with the traditional survey where I really thought personal feelings were in the way, and the QIS definitely, I thought, removed that, and we were all there for the same reason."

These provider responses are certainly not unanimous. In my frequent presentations on QIS over the last several years I have received a range of comments.

So why isn't QIS further along after 10 years?

First, development of a consistent quality of care and quality of life assessment approach spanning the full federal code of regulations turned out to be a difficult task. Formulating specific questions based on the regulations and interpretive guidance, developing structured protocols for conducting interviews and observations, and developing the software to support this data driven process all took time. Implementing a demonstration in five states where QIS was the survey of record had to be approached carefully to ensure that the process was feasible. Developing a cost-effective method to train surveyors to conduct QIS that ensured consistent application of the process was essential for larger scale roll out. Other systems have also had to change such as the Federal oversight and monitoring process, with regional office evaluators being trained in QIS and the QIS data being used to enhance their ability to identify inconsistency and improper application of the process.

In addition, the QIS demonstration had an independent CMS-funded evaluation that was completed more than a year later than projected. The evaluation (completed the end of last year) included observations of only 10 QIS surveys and was not conclusive due to the small sample sizes and other issues. According to the authors, "We qualify these findings by noting that comparisons between QIS and standard surveys were limited by sample size; thus the data we provide are best used for survey improvement purposes rather than to inform a decision about what type of survey process to use."[13] The evaluation didn't directly addressed the issue of consistency nor did the evaluators talk to QIS surveyors or staff in the facilities that were surveyed by QIS. However, the evaluators agreed that CMS should go forward with QIS and made recommendations about refinements to QIS that are being considered by CMS in the ongoing revision and improvement process.

Second, although many state surveyors, providers, resident advocates, CMS central office staff, and researchers are critical of the traditional survey process, many were initially reluctant to support large-scale changes. While survey and certification leaders in CMS, Helene Fredeking and Steve Pelovitz, were supportive of changes to the survey process at the start of the CMS development contract, it was not until more recently that a critical mass of CMS staff, including Thomas Hamilton, Cindy Graunke, Fred Gladden, Karen Shoenemann, Bev Cullen, Debra Swinton-Speares, Kathy Lochary, Linda O'hara, and Joan Simmons provided the necessary

[13] A. White, J Schnelle, R. Bertrand, K. Hickey, D. Hurd, D. Squires, R. Sweetland, and T. Moore. Executive Summary: Evaluation of the Quality Indicator Survey (QIS), Final Report for Contract #500-00-0032, TO#7. Cambridge, MA: Abt Associates Inc. page vi, 2007.

leadership and support to develop and implement QIS. Keeping the various stakeholders engaged in the QIS over the last ten years has also been essential.

Third, was the amount and uncertainty of the budget allocated to QIS. About $9 million in federal funds have been invested over ten years in QIS development, testing, and training for roll out in 6 states (CT, OH, KS, LA, FL, MN). Budget uncertainty has resulted in numerous state agencies applying to be trained in QIS and even purchasing hardware from their state budgets, and then being told to wait until CMS has the funds to train them. At the current rate of three new states per year, it will take about 15 years to roll QIS out nationally and even that may not happen unless there is a funding commitment so that survey agencies and states can prepare for training and purchase hardware. With the commitment to CMS of $20 million, training could be completed in all the states and the infrastructure development could be finished in less than five years.

Seeing what has happened in the states that have implemented QIS, I believe that there is nothing that would have a bigger impact on safeguarding the lives of nursing home residents and improving their quality of life than to fund the final refinement and implementation of QIS.

GLORIA A. EINSTEIN
President
MARTIN A. GOETZ, MS, MPA
Chief Executive Officer
BETTY S. SORNA, CPA, MAcc
Senior Associate Administrator/CFO
ELLIOTT PALEVSKY, MA
Senior Executive Director

January 3, 2008

Polly Weaver
Chief, Bureau of Field Operations
Florida Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida

Dear Ms. Weaver:

River Garden Hebrew Home for the Aged recently underwent a QIS inspection by a team working out of the Jacksonville field office. Since this was our first experience with the new QIS survey protocols and since Florida is at the forefront of implementation nationally, we thought we would share some thoughts that go beyond the standard post-survey on-line questionnaire.

Prior to our recent experience we were especially apprehensive around QIS and the effects it would have upon our Home and its culture of care. Many of us (including me) were initially concerned that too much reliance was being placed on the application of complex algorithms and technology; and that the purpose of the on-site inspection visit would be lost as professionals were diverted to "managing their computers." We were mistaken. Our experience was that the notebook computers kept surveyor attention focused on care and care related issues. Surveyors used their computers as interactive tools in driving the survey, but at no time did it appear that professional decision making had been relegated to computers.

Some thoughts now that we've had a few weeks to reflect upon the survey:

1. **Excellent Professionals:** Of the five AHCA surveyors, three of them had never surveyed us before, including the team leader, Judith Powell, RN. Four of the five on the team were nurses and the fifth was a long-standing surveyor, Stephanie Fox. These were outstanding surveyors who know the field well and represented AHCA, CMS, and their professions with excellence.

2. **Keep Survey Teams Intact**: It was apparent early on that the AHCA survey team was comfortable with the new survey and also with each other. We've come to more fully

appreciate that successful implementation of QIS requires significant teaming and bonding by surveyors, each to the other. We're convinced that AHCA and CMS will get its best and most consistent outcomes by having intact teams that know each other and work well together. During our recent survey we were particularly impressed by how well the team interacted with each other as well as with our residents, families, and staff.

2. **Communication and Anxiety Reduction:** This team did a superb job in communicating easily and well with virtually everyone with whom they came in contact. When our staff expressed curiosity to surveyors regarding their computer notebooks, your staff took a moment to show them what they were doing and how it was flowing into the system – I cannot begin to tell you how important those simple acts of courtesy and kindness were in helping alleviate anxiety and apprehension among staff.

3. **Focused Surveyors**: The QIS structure and process keeps everyone's attention focused and doesn't easily allow for "survey drift" (my term). We were continually impressed by the team's comfort with the new structure and process, and in their commitment to remain focused on tasks, timelines, and communication.

4. **Staff Retention:** Within this new CMS' survey model, significant resources, including money and time are clearly being invested in surveyor education and training. For this new survey protocol to be successfully implemented AHCA needs to be assured of a stable professional workforce that is adequately compensated. And while are not aware of compensation being a problem, should it be identified as one please let us know and we will try to help.

River Garden is an organization that places a high value on mission, competence, and tenure. We know what it looks and feels like when people are comfortable with one another, and this survey team was especially so. The team was proud of themselves and their mastery of the work. And you have right to be proud of them and their leader Nancy Marsh.

Sincerely yours,

Martin A. Goetz
Chief Executive Officer

MAG/rh

Mr. STUPAK. Thank you.

Mr. Pruitt, your opening, please.

STATEMENT OF NEIL L. PRUITT, JR., CHAIRMAN AND CEO, UHS-PRUITT CORPORATION

Mr. PRUITT. Thank you, Chairman Stupak, Ranking Member Shimkus and members of the committee. I am Neil Pruitt and I am chairman and CEO of UHS-Pruitt Corporation. I am grateful for the opportunity to be here on behalf of the American Health Care Association to offer perspective on the success and remaining challenges we face in ensuring quality nursing home care.

For nearly 40 years, my family-owned company has been providing professional healthcare services throughout the Southeast. With nearly 8,000 employees, we touch the lives of more than 18,000 individuals daily and we have a longstanding tradition of quality and a commitment to caring. I am proud of the advances our profession has made in delivering high-quality care, and we remain committed to sustaining these gains in the future when demand for care will dramatically increase.

Data tracked by CMS clearly illustrates improvements in patients' outcomes, increase in overall direct care staffing levels and significant decreases in quality of care survey deficiencies in our Nation's skilled nursing facilities. Positive trends are also evidenced by initiatives including Quality First and the Advancing Excellence in America's Nursing Homes campaign, which are having a significant impact on the quality of care provided. The Advancing Excellence campaign is a coordinated initiative among providers, caregivers, consumers, CMS and others that promotes quality and encourages best practices and evidence-based processes. This voluntary initiative is working and outcomes and processes are improving. We remain committed to building upon quality improvements for the future.

Twenty-one years ago, passage of OBRA 87 brought forth significant changes in our approach to patient care. Today we are in danger of abandoning the original intent of OBRA 87 in favor of a regulatory system that defines quality in a context that is often measured by fines and violations rather than by quality of care, or quality of life as was originally intended. We believe that a reformed and effective survey process should embody three guiding principles. The survey should be fair, accurate and consistent; protect the health and safety of the residents; and should focus on areas requiring improvement in problem. We must revamp the system to ensure that quality of life is emphasized consistent with the intent of OBRA 87.

We know the vast majority of nursing homes provide high-quality, compassionate care that patients and their families want and deserve. However, we recognize there is a very small fraction of facilities that do not meet these high standards of quality care. There should be incentives rather than current disincentives for new operators to take over troubled facilities and improve the care of the patients.

UHS-Pruitt has a history of purchasing facilities that have had troubled survey records and turning them into top-tier performing nursing facilities. We have been successful in working with the reg-

ulatory agencies in Georgia, North Carolina, and South Carolina to improve the quality of care delivered to those that we serve. I am proud of our organization's ability to improve underperforming facilities and make them a better place for our patients.

However, these efforts do not come without risk or difficulties. Last year we purchased a facility in Monks Corner, South Carolina. This was a facility with the SFF designation, which needed significant investment to reform it into a better environment that embraces the constructs of culture change, implements advances including information technologies, and has increased staffing levels. Prior to our purchase, this facility had been issued a Medicare notice of termination and efforts were underway to relocate more than 130 patients. Further, the center was one of the first to enter into a settlement agreement with CMS. Upon transfer of ownership, this agreement was renamed a systems improvement agreement. I believe that this type of agreement is a model for government-provider collaboration to improve care in underperforming nursing centers.

Before purchase, we presented a performance improvement plan to CMS and the South Carolina Department of Health and Environmental Control. Both the regulatory agencies offered valuable feedback on the past performance of the facility and the likely effectiveness of our plan to address past performance deficiencies. Our team holds periodic briefings with both agencies. These briefings are honest and open and are focused in achieving outcomes that will benefit patient care. While I am the first to admit the facility is still far from perfect, we are proud of our efforts and outcomes we have seen. This facility has had significant improvement and been publicly recognized by CMS regarding our intervention and success in improving this facility. It has been almost 8 months since we acquired the property. Over this time we have made considerable investment to improve the facility. However, we have still not been approved for Medicare certification and thus have not received any Medicare payments for the improved care and services we continue to provide.

We know that encouraging the purchase of troubled facilities can help patient care but there remain significant barriers with the current change of ownership process. This must be recognized and changed. There are ways to improve the regulatory process and ensure the current safeguards are adequate and appropriate. One inherent flaw with the current survey process is that it is incredibly subjective by nature. This is because the review relies upon the individual interpretation. There is, however, one system that has been mentioned that shows promise in reducing the human interpretation and subjectivity: the Quality Indicator Survey. We applaud CMS's latest attempt to minimize human variability. Although it is too early to draw conclusions on QIS, AHCA is cautiously optimistic that the process will help correct some of the inadequacies of the current system.

While I have provided a more thorough list of recommendations for a smarter oversight system in my written statement, some ideas include Congress to establish a pilot program in a few States that would require funds collected through civil monetary penalties to be put back into the system to improve quality care. Congress

should create a national commission that includes all long-term care stakeholders to best determine what information would provide assistance to consumers and how it should be made available. Encourage the posting of more complete staffing data on Nursing Home Compare. We also urge Congress to pass the Long-Term Care Quality and Modernization Act of 2007.

We are proud of the advances we have made in delivering high-quality long-term care and we remain committed to sustaining these gains in the years and decades to come.

I thank you for the opportunity to offer these comments and I look forward to answering your questions.

[The prepared statement of Mr. Pruitt follows:]

American Health Care Association

STATEMENT
Of
Neil Pruitt, Jr.

On Behalf Of The
AMERICAN HEALTH CARE ASSOCIATION

Before The

House Energy & Commerce Subcommittee on Oversight and Investigations
Hearing On
In the Hands of Strangers: Are Nursing Home Safeguards Working?

May 15, 2008

Thank you Chairman Stupak, Ranking Member Shimkus, 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 Neil Pruitt, I am Chairman and Chief Executive Officer of the UHS-Pruitt Corporation, and I am honored to be here today representing the American Health Care Association (AHCA).

For nearly forty years, since 1969, my family-owned company has been providing professional healthcare services throughout the Southeast. With nearly 8,000 employees, we touch the lives of more than 18,000 patients, residents and clients daily. UHS-Pruitt has a rich and long-standing tradition of quality and a "commitment to caring." The mission we embrace that drives our work every day is "Our family, your family, ONE FAMILY; Committed to loving, giving and caring; United in making a difference."

On behalf of the profession responsible for caring for our nation's most vulnerable citizens, I am proud of the advances we have made in delivering high quality long term care services and we remain committed to sustaining these gains in the years and decades ahead – when, as we all know, demand for long term care will by all accounts dramatically increase.

Americans are living longer and our nation's aging population is growing – many of whom have medical or cognitive conditions which require care in a nursing facility. Currently more than three million Americans rely on the care and services delivered in one of the nation's nearly 16,000 nursing facilities each year. The forecast for the demand for nursing facility care is alarming. A March 2008

report from the National Investment Center for the Seniors Housing & Care Industry (NIC) indicates that the demand for long term care services will more than double by 2040.

I am proud of the efforts and initiatives advanced by the association that I represent today that seek to enhance and improve quality of care and services provided in our nation's nursing facilities each day.

Quality – AHCA's First Priority

Long before the words quality and transparency were the catch words of the federal government and their oversight of healthcare, they were truly the compass for the American Health Care Association and its member facilities.

Our association's long-held mission clearly states, "our goal is to provide a spectrum of patient/resident-centered care and services which nurture not only the individual's health, but their lives as well, by preserving their connections with extended family and friends, and promoting their dignity, respect, independence, and choice."

AHCA has been working diligently to change the debate regarding long term care to focus on quality – quality of life for patients, residents and staff; and quality of care for the millions of frail, elderly and disabled individuals who require our services. We have been actively engaged in a broad range of activities which seek to enhance the overall performance and excellence of the entire long term care sector. While keeping patients and their care needs at the center of our collective efforts, we keep challenging ourselves to do better, and enhance quality.

The Facts Speak for Themselves – Quality & Outcomes Are Improving

The Online Survey, Certification and Reporting (OSCAR) data tracked by the Centers for Medicare and Medicaid Services (CMS) clearly points to improvements in patient outcomes, increases in overall direct care staffing levels, and significant decreases in quality of care survey deficiencies in our nation's skilled nursing facilities.

A few examples which highlight some of the positive trends in nursing facility care according to data tracked by CMS:

- Nationally, direct care staffing levels (which include all levels of nursing care: Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs)) have increased 8.7 percent between 2000 and 2007 – from 3.12 hours per patient day in 2000 to 3.39 hours in 2007;

- The Quality Measure[1] tracking pain for long term stay residents vastly improved from a rate of 10.7 percent in 2002 to 4.6 percent in 2007 – more than a 50 percent decrease;

[1] **Quality Measures** track nursing facility residents who have and are at risk for specific functional problems needing further evaluation. Improvements in these measures indicate positive trends in patient outcomes, but it is important to clarify that the quality measures do not reflect a percentage of the entire population, rather the percentage of those who are at risk and have the condition.

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

- The Quality Measure tracking the use of physical restraints for long stay residents dropped from 9.7 percent in 2002 to 5.6 percent in 2007;

- The Quality Measure tracking pressure ulcers for post-acute skilled nursing facility patients (many of whom are admitted to the nursing facility with a pre-existing pressure ulcer) improved by 23 percent over the course of four years, from 20.4 percent in 2003 to 15.8 percent in 2007; and

- Substandard Quality of Care Citations as tracked by CMS surveys were reduced by 30 percent in five years – from 4.4 percent in 2001 to 3.1 percent in 2006.

- In January 2006, the Government Accountability Office stated that from 1999-2005 there was a nearly 50 percent decrease in the "proportion of nursing homes with serious quality problems."

Satisfaction of patients and family members is a critical measure of quality. AHCA has recognized this vital link between satisfaction and performance, and has urged facilities to conduct such assessments for more than a decade. In recent years, we have encouraged facilities to use a nationally-recognized company, *My InnerView*, to conduct consumer and staff satisfaction surveys to establish a national database for benchmarking and trend analysis. Last year's independent survey of nursing home patients and their families 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.

AHCA remains committed to sustaining – and building upon – these quality improvements for the future.

Culture of Cooperation – Leading to Continued Improvement

Positive trends related to quality are also evidenced by profession-based initiatives including *Quality First* and the *Advancing Excellence in America's Nursing Homes* campaign – both of which are having a significant impact on the quality of care and quality of life for the frail, elderly and disabled citizens who require nursing facility care.

Quality First, which was established in 2002, set forth seven core principles that reflect long term care providers' commitment to continuous quality improvement, leadership and transparency. This profession-based initiative led not only to improvements in care and processes, but to the development of the National Commission for Quality Long-Term Care. In December 2007, the Commission released its final report which addressed four critical components of long term care – quality, workforce, information technology & financing. We encourage Congress to take the recommendations of this commission under consideration – and further investigate their feasibility.

Quality First and other initiatives have been recognized by former Secretary of Health & Human Services Tommy Thompson, by former Administrator of CMS Dr. Mark McClellan, and by former CMS Acting Administrator Leslie Norwalk last year when she stated in a column she wrote for

Provider magazine: "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…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."

AHCA is a founding partner of the *Advancing Excellence in America's Nursing Homes* campaign – a coordinated initiative among providers, caregivers, consumers, government and others that promote quality around eight measurable goals. This campaign takes a step further than previous initiatives. It not only measures outcomes, but it establishes numerical targets and benchmarks. It also promotes best practices and evidence-based processes that have been proven to enhance patient care and quality of life.

This voluntary initiative is working – and outcomes and processes are improving in the nearly 7,000 participating facilities. In December 2007, the campaign announced that for the first three quarters of the initiative, there was progress in reducing the incidence of pressure ulcers in nursing homes, reducing use of physical restraints, managing pain for long term nursing home residents, and managing pain for short stay, post-acute nursing home residents. Our association is diligently working to increase the number of facilities that actively participate in this program and embrace the concepts embodied in the *Advancing Excellence in America's Nursing Homes* campaign.

In his November 2007 testimony before the U.S. Senate Special Committee on Aging, Acting CMS Administrator Kerry Weems praised the *Advancing Excellence in America's Nursing Homes* campaign, stating, "This campaign is an exceptional collaboration among government agencies, advocacy organizations, nursing home associations, foundations, and many others to improve the quality of nursing homes across the country."

Further, in the CMS 2008 Action Plan for (Further Improvement of) Nursing Home Quality, the agency states that it "plan[s] to strengthen our partnerships with non-governmental organizations who are also committed to quality improvement in nursing homes…The unprecedented, collaborative [*Advancing Excellence in America's Nursing Homes]* campaign seeks to better define quantitative goals in nursing home quality improvement. The purpose of this campaign is to align the strategies of the many partners who have expressed their commitment to excellent nursing home quality."

We applaud CMS for their commitment to further enhance care quality and outcomes through this partnership of stakeholders. The effort truly embodies the culture of cooperation which is critical in effectively enhancing care and sustaining quality improvements.

We are engaged in discussions with the Office of Inspector General (OIG) regarding quality issues for long term care. AHCA and member organizations – including UHS-Pruitt – were active participants in a 2007 OIG and Health Care Compliance Association roundtable. This provided us the opportunity to educate both the federal government and other stakeholders on our profession's current quality improvement efforts and initiatives. As a result, UHS-Pruitt and other AHCA member companies have created and implemented "quality dashboards."

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

In an August 2006 speech before the National Governors Association, U.S. Department of Health and Human Services Secretary Mike Leavitt proclaimed that the nursing facility profession has moved forward in addressing financial integrity and transparency. Secretary Leavitt stated, "a wonderful thing is happening in the nursing home industry – they started posting their quality measures and their prices…and [because of] public disclosure of them they immediately began to improve and the price got lower and the care got better because the providers themselves said we don't want to be in a place where we are compared negatively because it will affect our market."

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. AHCA remains committed to its long-standing practices and programs which seek to improve the quality of care for our nation's most frail, elderly and disabled who require long term care services, and enhance the quality of life for patients and caregivers alike.

Current Regulatory System

Twenty-one years ago, passage of the *Omnibus Budget Reconciliation Act of 1987 (OBRA '87)*, which contained the *Nursing Home Reform Act,* 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 evaluation of each patient using a uniform assessment tool – the Minimum Data Set (MDS). It was equally important that each facility needed to create and use an ongoing quality assessment and assurance committee; this offers a platform from which each facility can evaluate the daily processes and procedures that generate positive patient outcomes.

The resident-centered, outcome-oriented, consistent system of oversight that was originally intended has failed to focus on Quality Care.

Today we are in danger of abandoning the original intent of OBRA 87' in favor of a regulatory 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 intention.

In fact, a January 2006 GAO report on nursing home oversight indicates that the nation's Survey and Enforcement System for nursing homes is consistently inconsistent, with significant variations from state to state. AHCA and our members have long maintained that a one-dimensional punitive approach does not get to the overall goal of achieving quality care.

Today's regulatory construct is based upon yesterday's nursing facility and does not account for the shift in the patient mix and the type of care and services being delivered. Independent studies validate the fact that skilled nursing facilities are providing intensive rehabilitation and nursing care to a

growing number of short-stay patients who return to their home and community, often within one month. At the same time, an increasing percentage of the nation's nursing facility population has significant cognitive difficulties – including advanced Alzheimer's disease – and more disabilities. Despite changes in patients and care provided, changes to the oversight system have not kept pace.

AHCA believes that achieving a sustained level of quality care will only be fully realized when there is a collaborative effort to recognize and implement improved health care technologies and best clinical practices designed to improve and enhance patient outcomes. This type of culture change is essential to appropriately address the needs of a growing patient population and a shrinking pool of caregivers.

A cooperative approach that is producing tremendous results and effectively improving the care and outcomes in our nation's nursing facilities is the partnership between facilities and Quality Improvement Organizations. These professionals share best practices and techniques, and working with the facilities in partnership, they identify opportunities and provide assistance for improvement. In fact, nursing homes working with QIOs in a national collaborative project, successfully reduced the incidence of the most serious bed sores by 69 percent in one year.

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.

We believe that such a reformed, fair and effective survey process should embody three guiding principles:

- Surveys should be fair, accurate and consistent,
- Surveys should protect the health and safety of residents, and
- Surveys should focus on areas requiring improvement.

We must revamp the system to ensure that the quality of life of the residents is emphasized, consistent with the intent of *OBRA '87*.

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

Recognizing Barriers to Improving Quality

The vast majority of nursing homes across the nation provide the type of high quality, compassionate care that patients, residents and their families want and deserve. However, we recognize that there is a very small fraction of nursing homes that do not meet high standards of excellence and care quality. Begun in 1998, the Special Focus Facility (SFF) program has brought more attention to bear on nursing homes that have a poor survey history. Sadly, some of these facilities ultimately close, resulting in trauma to the patients who must move from their home, their families, and the staff.

There should be incentives – rather than the current disincentives – for new high quality operators to take over troubled facilities and improve the care for patients and the entire environment for staff, patients and family members alike.

UHS-Pruitt has a history of purchasing facilities with the SFF designation – or those that have had a troubled survey record – and turning them into top tier nursing facilities. We have had great success working with the regulatory agencies in Georgia, North Carolina and South Carolina to improve the quality of care delivered to those that we serve. I am proud of our organization's ability to improve under-performing facilities and make them a better place for patients to receive high quality care and services. However, these efforts do not come without risk or difficulties.

Last year, we acquired a facility in Monck's Corner, South Carolina, which we subsequently renamed UniHealth Post Acute Care- Monks Corner. This was a facility with the SFF designation, and it needed significant investment to reform the facility from an outdated "old time nursing facility" to an updated and reformed environment that embraces many constructs of culture change, implements advances including information technologies, and has increased staff levels.

Prior to our purchase, this facility had been issued a Medicare notice of termination and efforts were underway to relocate the more than 130 patients in the facility. Further to my knowledge, the center was one of the first to enter into a settlement agreement with CMS. Upon transfer of ownership this agreement was renamed a Systems Improvement Agreement. It is my belief this type of agreement is a model for Government/Provider collaboration for improvement of care in underperforming nursing centers. Before purchase, UHS-Pruitt presented a performance improvement plan to CMS and the South Carolina Department of Health and Environmental Control (DHEC). Both regulatory agencies offered valuable feedback on the past performance of the facility and the likely effectiveness of our plan to address historic performance deficiencies. Our team holds periodic briefings with CMS and DHEC. These briefings are honest and open and focused on achieving outcomes that ultimately will benefit the patients served by UniHealth Post Acute Care- Monks Corner.

While I am the first to admit, the facility is still far from perfect, we are proud of our efforts and the outcomes we have witnessed. This facility has seen significant improvement and UHS-Pruitt was publicly recognized by CMS regarding our intervention and success in improving this facility, stating that the facility "is on track to graduate from the Special Focus Facility Initiative provided it can sustain the improvements over time." We agree with Administrator Weems' statement of November 2007 that "the Special Focus initiative can pay great quality-of-care dividends for nursing home residents."

However, as I stated earlier, it is not an easy process, nor is it without significant risk.

It has been almost eight months since we acquired this property. Over this time, we have made considerable investment in enhancing and improving the facility, and as CMS attested, they have witnessed significant advancements. However, at this time, we still have not been approved for Medicare certification, and thus have not received any Medicare payments for the improved care and services we continue to provide. This is a barrier that precludes many potential buyers from purchasing a facility and it should be eliminated in order to better facilitate exemplary operators acquiring troubled facilities.

We know how encouraging the purchase of troubled facilities can generate success, but there remain significant barriers with the current change of ownership process. This must be recognized and changed.

When a reputable individual or entity steps forward to purchase, the new owner not only acquires the physical structure, but the entire survey history as well – including deficiency citations, and fines and penalties incurred. For example, if the facility has had their nurse aid training suspended, that will also carry over under the new ownership.

In order to encourage new investment in troubled facilities that may face closure, Congress and CMS should revise the rule for transfer of ownership to lessen the burden on the new owner/operator and consider the suspension of certain fines and penalties when purchase of the facility is demonstrated to be an arms length transaction. 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 entities to purchase a problem facility in order to improve it and restore quality of care by removing insurmountable obstacles at the outset which might otherwise discourage them from making the purchase.

In short, new owners and operators should not be penalized for past performance under previous owners, but rather encouraged to invest their financial resources and commitment to the improvement and ultimate success of the facility.

A Stable, Well-trained Workforce is the Building Block of Quality Long Term Care

All of us in this profession are acutely aware that human contact is essential to treating long term care patients and residents, and you will never be able to replace the role that people play in providing long term care. AHCA has long recognized that the provision of high quality long term care and services is dependent upon a stable, well-trained workforce. However, America's long term care system is currently suffering from a chronic supply and demand problem when it comes to our labor force. Addressing this challenge on both fronts is the only real means to sustain the provision of high quality long term care.

We are committed to partnering with Congress, the Administration, and other long term care stakeholders to ensure a qualified and well-trained staff is in place to care for our nation's elderly and disabled today – and in the coming years when the current crisis will hit epidemic proportions unless government intervenes. But as a first step toward this laudable goal, we agree with the *National Commission for Quality Long-Term Care* that there must be recognition that the long term care workforce is "a critical component of the nation's labor force – separate and distinct from the health care labor market."

A recent report by this same quality commission highlighted this impending catastrophe when it stated "even if we set the somewhat conservative goal to maintain the current ratio of paid long-term care workers to the current population of 85-year-olds, the long-term care workforce would have to grow by two percent a year – to the tune of 4 million new workers – by 2050."

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

The high demand for long term care workers is already documented by the federal government. A recent study by the Department of Health and Human Services (HHS) and Department of Labor (DOL) estimates the U.S. will need between 5.7 million to 6.5 million nurses, nurse aides, and home health and personal care workers by 2050 to care for the 27 million Americans who will require long term care – up more than 100 percent from the 13 million requiring long term care in 2000.

Vacancies and turnover in the long term care profession compromise sustained quality improvements and increase costs. In fact, a recent report from the *National Commission on Nursing Workforce for Long-Term Care* concluded that "efforts to recruit and train new nursing staff are estimated to cost nursing facilities over $4 billion each year – more than $250,000 annually for each nursing home in the nation.

While efforts to recruit and train new qualified long term caregivers are costly, our profession has been aggressively pursuing potential nurses and caregivers. An unfortunate truth exists that nursing education programs are forced to turn away well-qualified applicants for the sole reason that there are not enough nurse educators to train these potential caregivers. In fact, the American Association of Colleges of Nursing found in its annual survey that more that 40,000 qualified applicants were not accepted into nursing programs primarily because of insufficient nurse faculty for the 2007-2008 academic year.

AHCA is Leading Efforts in Transparency in Health Care

As was reinforced by former CMS Administrator Norwalk and HHS Secretary Leavitt, the long term care profession was the first among health care providers to subscribe to true transparency and publicly available information as to our performance. We were willing partners with CMS and HHS in disclosing more information that we hoped would be helpful to consumers when facing a difficult decision for choosing a nursing facility.

We firmly believe that calls for increased disclosure on details such as minimal ownership of a nursing facility will not drive – nor contribute to – the improvement of care or services in facilities nationwide. We must look to empower those individuals, such as administrators or facility operators, who make the decisions which impact the care that is delivered daily.

The disclosure of more information does not necessarily lead to better quality or better informed consumers. In fact, disclosure of confusing, inaccurate or conflicting data leads to greater misunderstanding. Rather than promoting disclosure for disclosure's sake, we must ensure that available reported data is in the best interest of consumer needs. The culture of cooperation should be engaged to ensure that the data reported is the correct – and most useful – information for consumers to make an informed decision as to a quality nursing facility.

Rather than the current construct of reportable data, we believe that other data components must be considered such as: family and patient satisfaction, staff turnover, patient outcome trends, the specialties and focus of the facility, and the patient acuity. Above all else, we must work together to

ensure such data is accurate, up to date and presented in a fashion that is easily understandable and useful to consumers.

Stability is Critical for Profession to Sustain Quality Gains

It is important to recognize the nursing home of the 21st century is far different from its predecessors, and while it's excellent news that patients are returning home more quickly, threatened cuts to Medicare funding are increasingly problematic when caring for older, sicker, and more medically complex patients.

A recent report from the United Hospital Fund documents the growing role that skilled nursing facilities play as providers of short-term care for individuals recuperating after a hospital stay. The report finds that the "number of patients staying in a nursing home for less than two months more than tripled," from 1996 to 2005.

Just last week, CMS issued a proposed rule for fiscal year 2009 payments to skilled nursing facilities, which would cut Medicare Part A payments for skilled nursing care by $770 million in the first year alone, or $5 billion over five years. Cutbacks of this magnitude not only threaten the progress we have achieved working with the federal government to improve care quality, but reduce our profession's ability to maintain quality improvement initiatives taking place on the front lines of care that are currently making a difference in the lives of our residents and those caregivers providing critical care and rehabilitative services.

These cuts are exacerbated by the chronic underfunding by Medicaid for care and services provided in our nation's nursing facilities. A recent *BDO Seidman/Eljay, LLC*, study projected that states cumulatively underfunded the actual cost of providing quality nursing facility care by $4.4 billion in 2007. The analysis further showed the average shortfall in Medicaid nursing home reimbursement was $13.15 per patient day in 2007 - a 45 percent increase from 1999.

And while financial stability is an essential component of delivering high quality long term care services, it is just as critical for the profession to maintain a stable workforce. Nearly 70 percent of skilled nursing operating costs are labor-related. Ongoing funding shortfalls have a major impact on the front lines of care and negatively influence staffing, jeopardize intra-facility quality improvement efforts, and even may cost the jobs of the very staff that make a key difference in the quality of care and quality outcomes.

So we ask you Mr. Chairman, how can dedicated providers of skilled nursing care meet the ongoing demands of the federal government for increased staffing levels and sustained quality improvements with reduced funding?

Ensuring Adequate & Appropriate Safeguards

I am here today to discuss ways we can improve the regulatory process and ensure that current safeguards are adequate and appropriate.

One inherent flaw with the current survey process is that is it incredibly subjective by nature – this is because the review inherently relies upon individual interpretation of a situation. With different interpretations by individuals and survey teams, it is easily understandable why there is great variability in the process. This reality was highlighted in a recent analysis by LTCQ, which found that for states with more than five survey districts, there were significant differences from one district to another. The data illustrated that there was a wide range of interpretation, in particular, for skin care standards and medication administration.

There is, however, one system that shows promise in reducing the human interpretation and subjectivity of the current process – this is the Quality Indicator Survey (QIS). We applaud CMS's latest attempt through the automated QIS survey process to minimize human variability. Although it is far too early to draw comprehensive conclusions on QIS, AHCA is cautiously optimistic that the process will help correct some of the inadequacies of the current system.

We believe that it is possible to do a better job of accurately identifying those facilities that need a more thorough, detailed review during an annual survey versus those facilities that, although not perfect, consistently reflect quality care and substantial compliance with the regulatory requirements. In identifying these facilities, we feel it would enable the CMS surveyors and the QIOs to focus their limited resources on the facilities and patients that will benefit most from additional attention. Such changes, we feel, would lead to a smarter, more effective survey system.

Recommendations for a Smarter Oversight System

- We ask that Congress consider establishing a pilot program in a few states that would allow funds collected through civil monetary penalties (CMPs) to be put back into the system to improve quality care. In my home state of Georgia, the CMPs were used effectively in a quality improvement program that assisted facilities in paying for an automated quality dashboard and customer satisfaction surveys. In Arkansas, the state is using CMP funds to fund their Local Area Network for Excellence as part of the *Advancing Excellence in America's Nursing Homes* campaign and funding satisfaction surveys to determine how residents, families and staff feel about the facility and services received. These are just two examples of how the collected funds can be reinvested into facility improvements.

- In order to encourage new investment into troubled facilities that may face closure, Congress and CMS should consider the suspension of certain fines and penalties when a facility is being purchased in an arms length transaction by an individual or entity that has 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.

- Congress should consider creating a national commission that includes all stakeholders in long term care – CMS, owners/operators, caregivers, families, residents, and advocacy organizations – in order to best determine what information would provide assistance to consumers, and how

it should be made available. Current information on Nursing Home Compare and other online resources is often times outdated and confusing. By determining what is helpful to consumers, the commission can create improved resources that are more user-friendly, and contain meaningful information.

- Congress should amend the charter of the Medicare Payment Advisory Commission (MedPAC) to require the Commission to consider operating margins of all government payers, the adequacy of all government funding, and the effects of the interaction between the Medicare and Medicaid programs on nursing facilities. This approach will enhance economic stability and quality improvements.

- We encourage CMS to provide evidentiary legal protections for information disclosed by those facilities that are voluntarily participating in the *Advancing Excellence in America's Nursing Homes* campaign. Facilities who participate in such programs have made a public commitment to high quality care – and there should be incentives for facilities to make that same, voluntary commitment to track and improve eight measurable goals.

- We support the idea of posting more complete staffing data on Nursing Home Compare for consumer use. This data would include all caregivers in a facility, including physical and occupational therapists, speech-language pathologists, nurse practitioners, and all contract nurses to truly reflect the number of hands-on caregivers in each facility. The staffing levels should also be placed in context on Nursing Home Compare with an indication of the patient mix or acuity in the facility, providing a better indication as to why a facility may have a higher or lower level of staffing.

- We also urge Congress to pass *The Long Term Care Quality & Modernization Act of 2007(H.R 4082)*. This important legislation, authored by Representatives Earl Pomeroy (D-ND), Shelley Moore Capito (R-WV) and Tom Allen (D-ME) aims to enhance long term care by encouraging policy changes that will promote quality of care in the nation's long term care settings, and modernize payment and other systems to keep pace with advances in medicine and medical technology. The field of providing care to the nation's long term care patients is changing, and so should the laws that help govern it. Specifically, the bill would:

  - Enhance quality by training long term care providers and state surveyors together on rules and regulation to enhance compliance;

  - Modernize outdated "consolidated billing" rules that have not kept pace with advances in medical technology and medicines to treat cancer;

  - Amend a recent HHS rule regarding treatment of nursing home residents with diabetes;

  - Update Medicare rules requiring that patients spend three days in a hospital before being admitted to a skilled nursing facility;

- Protect Medicare Part B beneficiaries by extending the current exceptions process for outpatient therapy services;
- Direct the Secretary of Health and Human Services to create a Long-Term Care Quality Advisory Commission. The purpose of the Commission is to develop and facilitate implementation of a national plan for long term care quality improvement;
- Remove barriers in place in order for more nurses to receive assistance through the *Nurse Reinvestment Act*;
- Study the growing crisis of shortages in the nurse and physical therapy professions; and
- Enhance quality of long term care facilities by updating current tax law regarding the reconstruction and modernization of nursing homes and other long term care settings

We agree that not only do consumers deserve the highest quality care and services across the spectrum of health care settings, but also employees deserve well-paid, positive work environments. As the profession responsible for the care of our nation's most vulnerable citizens, we are proud of the advances we have made in delivering high quality long term care services and we remain committed to sustaining these gains in the years and decades ahead.

Thank you for the opportunity to offer these comments on behalf of millions of professional, compassionate long term caregivers and the millions of frail, elderly, and disabled Americans they serve each day. I look forward to responding to your questions.

###

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

Mr. STUPAK. Thank you, Mr. Pruitt.

Dr. Koren, your opening statement, please.

STATEMENT OF MARY JANE KOREN, M.D., M.P.H., ASSISTANT VICE PRESIDENT, THE COMMONWEALTH FUND

Dr. KOREN. Thank you, Mr. Chairman, for inviting me to testify. I am Dr. Mary Jane Koren. I am a geriatrician and I am here to testify on my own behalf as an expert in this field. Besides having been a nursing home physician and having had a father in a nursing home, from 1987 to 1992 I was the director for survey and certification for New York State. I have also been privileged to be a member of the National Commission on Quality Long-Term Care, which was chaired by former Senator Bob Kerrey, and former House Speaker Newt Gingrich.

Currently, I am an assistant vice president of the Commonwealth Fund, where I direct a program to improve nursing home quality, and I have the honor to be this year's chair of the steering committee, which, if I may comment, is actually an independent coalition of stakeholder groups and is really not sponsored by any one given organization.

This Advancing Excellence so far has over 43 percent of the nursing homes in the country as participants. I would like to thank you, Chairman Stupak and also Ranking Member Shimkus and every member of the committee for conducting these hearings today since recent events have brought to light important issues with the nursing home oversight system and how quality may be achieved in the Nation's nursing homes. I would like to tell you about some of the positive changes that have been occurring and that continue to spread.

I believe that survey and enforcement is a critically important undertaking because it really sets a floor of what we expect all nursing homes should be doing. I also think it should be easy to find out where the buck really stops when there are problems so that they can be fixed expeditiously and permanently. However, while I agree that our current survey system of oversight could and should be improved, I don't think we should rely on the regulatory process to improve quality of care alone and we certainly shouldn't ask our surveyors to become consultants to the industry.

There are other ways government can help improve nursing homes. For example, Washington State has a quality assurance nurse program as a separate and distinct unit from its survey agency. In addition, a federally supported quality improvement organization program could be charged to help nursing homes come into compliance after survey and continue to work collaboratively with voluntary efforts such as happening now with two initiatives which I would like to tell you about briefly.

The first is called Culture Change. It is a grassroots movement which began about 15 years ago when a number of people suddenly tapped into OBRA 87's potential to promote resident-centered care and to really try to turn nursing homes into homes. Picture a nursing home where you can stay up to watch the end of the ballgame, you can get yourself a midnight snack and then you are helped to bed by somebody who actually knows you and all your little quirks. This is light years away from business as usual but it is something

that is happening more and more. It is applicable whether you stay in a nursing home for 5 days or whether you stay there for 500 days. Findings from a recent national survey of nursing homes supported by the Commonwealth Fund showed that over half the facilities in the field say that they are either doing something to try to make themselves more resident-centered or that their leadership is committed to the principles of resident-centered care and that they will begin shortly.

Likewise, the survey found that adopters are beginning to see a positive impact on their bottom line. The Quality Improvement Organization program's 8th Scope of Work borrowed from the culture change movement to target things like how to retain staff and ways to help staff really get to know their residents and to test resident satisfaction. This boosted interest across the industry in resident-centered care. At the same time, CMS's Office of Survey and Certification has been trying to ensure that the survey process itself not become a barrier to innovation.

The other positive development is Advancing Excellence, which several of you here have mentioned today. This effort is less than 2 years old. The campaign's national steering committee which, as I said, I do chair, is made up of an unprecedented coalition of 30 organizations including provider associations, health professionals, unions, consumer advocacy groups, and representatives from CMS. The collaborative spirit of the group itself deserves to be counted as one of its most noteworthy accomplishments. The campaign has been very successful so far. It has opened all nursing homes, not just those in the association. It also seeks support and participation from consumers and frontline staff. We are tracking the clinical goals and results already show that it is working. Participant homes are improving at a faster rate for the clinical goals than homes which have not yet joined. Forty-nine State-level networks have been established that are very efficient ways to get good ideas out there and provide technical assistance to homes. One call that we had, we have over 10 percent of the industry actually on that call to hear about evidence-based ways to improve performance in taking care of pressure ulcers.

In addition, I would like to conclude my remarks by observing that there are a number of steps Congress could take that would really support current voluntary efforts while at the same time improving transparency and the regulatory process. They include the CMS Web site, Nursing Home Compare, include information on multiple staffing characteristics and the rate of consistent assignment, and also perhaps whether or not a nursing home is participating in Advancing Excellence. Also, CMS should be charged with developing payment methods that would reward nursing homes participating in the campaign or achieving results on adopting resident-centered care practices. Also, CMS should be encouraged to continue to make long-term commitments to supporting Advancing Excellence and similar efforts at quality improvement. Perhaps also we should direct CMS to fund and conduct a demonstration to pilot other ways to provide technical assistance that could be linked to the survey process but not be provided by the survey agency. And lastly, that CMS be directed to continue to vigorously pursue

its work on using resident input to improve the assessment, the care planning and the survey processes.

Thank you.

[The prepared statement of Dr. Koren follows:]

MOVING TO A HIGHER LEVEL:
HOW COLLABORATION AND COOPERATION CAN IMPROVE NURSING HOME QUALITY
For the hearing of the House Subcommittee on Oversight and Investigations
Summary of invited testimony of Mary Jane Koren, M.D., M.P.H,
Assistant Vice President, The Commonwealth Fund
May 15, 2008

- The survey and enforcement process is critical to upholding minimum standards of performance. It is a process that should be improved
  - By better using data and other means to reduce inconsistencies
  - To be more transparent as to accountability and provide better information to consumers faced with having to compare facilities.
- However, to actually improve care beyond that baseline level of performance other mechanisms must be used in addition to the regulatory process. Two examples of voluntary efforts appear to be making a difference.
  - **The Culture Change movement**, led by the Pioneer Network, makes nursing homes "resident-centered" by
    - encouraging residents to make choices about their daily routine, valuing them as individuals and making their lives worth living
    - empowering front line works by giving them needed training and resources, letting them make decisions that most affect their work and the residents they care for and giving them recognition.
    - Creating a home-like environment
  - **Advancing Excellence, the Nursing Home Quality Campaign** is a voluntary, public private partnership led by a coalition of key stakeholders to measurably improve care in four clinical domains and four system areas
    - So far almost 7,000 nursing homes (43% of the total) have joined
    - Participating homes are improving in the clinical target areas faster than non-participant homes.
- **Recommendations** for Congressional action include:
  1. That the CMS web-site Nursing Home Compare include information on
     - Multiple staffing characteristics and consistent assignment; and
     - Whether or not a home is participating in the campaign;
  2. That CMS be charged with developing payment methods that would reward nursing homes participating in the campaign and/or achieving results on adopting resident-centered care practices;
  3. That the QIO program
     - Continue to provide support for the campaign, continue to be part of the local networks and help providers improve in the eight target areas;
     - Be designated as the appropriate locus for technical assistance to providers rather than the survey agency; vement; and
  4. That CMS be directed to vigorously pursue its work on using resident input to improve the assessment, care planning and survey processes.

MOVING TO A HIGHER LEVEL: HOW COLLABORATION AND COOPERATION CAN IMPROVE NURSING HOME QUALITY

Mary Jane Koren, M.D., M.P.H.
Assistant Vice President
The Commonwealth Fund
Chair of Advancing Excellence:
the National Nursing Home Quality Campaign
One East 75th Street
New York, NY 10021
mjk@cmwf.org

Invited testimony before
U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
Hearing entitled *In the Hands of Strangers:*
Are Nursing Homes Safeguards Working

May 15, 2008

Thank you, Mr. Chairman, for this invitation to testify today. I am Dr. Mary Jane Koren, a geriatrician by training, and I've been involved with nursing homes for over 25 years. I've taken care of nursing home residents, taught medical students and geriatric fellows in nursing homes and done research on nursing home quality. In addition, I was the Director of New York State's Bureau of Long-Term Care, which oversaw the survey and certification process for New York's over 600 nursing homes, pilot tested a new federal survey process for, then, HCFA and implemented the Nursing Home Reform Law, OBRA'87, in New York. More recently, only last year, I sat by my father's beside in a nursing home during his final months.

I have also been privileged to be a member of the National Commission for Quality Long-Term Care chaired by former Senator Bob Kerrey and former House Speaker Newt Gingrich. Currently, I am an assistant vice president of the Commonwealth Fund, where I manage a program aimed at improving nursing home quality, and I have the honor of serving as this year's Chair of the Steering Committee for Advancing Excellence, the Nursing Home Quality Campaign which already has recruited over 43% of the country's nursing homes as participants. I thank Chairman Stupak and Ranking Member Shimkus—and every member of the Committee – for conducting this hearing on nursing home quality since recent events have brought to light significant issues with the nursing home oversight system and raise important questions about how better quality may be achieved. I would in no way dispute many of the concerns expressed here today but I am here to tell you about some of the positive changes that have been occurring and that continue to spread across the industry and make several recommendations for actions that you, as members of Congress, could take.

As a former survey director I would like to say that I believe a strong survey and enforcement process is vitally necessary. Beyond government's responsibility to be a prudent purchaser of services it has the obligation to protect the safety and well being of all members of "the community", holding providers responsible for meeting regulatory requirements. I would note that I was fortunate in New York where the public health law does not permit a business corporation to operate a nursing home unless its stock is

owned by natural persons or by a Limited Liability Company (LLC) whose membership interests are owned by natural persons, statutory requirements which made accountability easier to ascertain. Nevertheless, while recognizing that the regulatory process is a highly legitimate function, there is no doubt it could be improved. Smarter use of available data could make it more consistent and fairer to providers, use of input from residents could make it more responsive to unmet needs, and it should provide additional, useful information for the public.

However, while the regulatory process is an important mechanism to uphold a minimum standard of performance, it has not proven itself to be the most effective method for lifting performance over and above that minimum threshold of nursing home of quality. That being said, the nursing home component of the Quality Improvement Organization (QIO) program, in conjunction with two voluntary initiatives, one long-standing and the other relatively new, are moving nursing homes to a higher level of performance. I would like to briefly describe these very promising developments in the field of nursing home quality.

The first is what's known as "Culture Change", a grass roots movement, which has since come together as the Pioneer Network, that began about 15 years ago when a number of providers used OBRA'87's previously untapped potential for person, or resident-centered care to turn nursing homes into homes. Picture a nursing home where you can stay up to watch the end of the ball game, get yourself a midnight snack and be assisted to bed by an aide who's gotten to know all your little quirks and enjoys listening to your stories. This is light years away from the usual way of doing business but it's an approach to service delivery that is as applicable for someone staying in a nursing home for five days as for someone staying for five hundred days. This type of transformation is not just wishful thinking as is shown in the findings from a recent national survey of nursing homes supported by the Commonwealth Fund which paint a hopeful, if still somewhat mixed, picture: At least one third of the field say they are actually doing something to try to make themselves resident centered. For example, they are giving residents more choice in determining their daily routine and empowering front line

workers. Another 25%, although they have not yet started on the journey to making changes, have leaders within the facility committed to the principles of resident-centered care. Interestingly, staff resistance to change is seen as one of the major barriers to adoption. Likewise, the survey found that adopters are beginning to see a positive impact on their bottom line. (The full report can be accessed at www.commonwealthfund.org). The visibility of the culture change movement was increased when the QIO program's 8th Scope of Work borrowed from the movement's focus on deep system change for its contract tasks. Some of these, such as decreasing the very high levels of turnover so endemic in the industry and increasing the consistent assignment of nurses aides to a given resident are fundamental steps to being able to improve quality. At the same time, CMS's office of survey and certification has been extremely forward-thinking. It has developed tools for providers and others, such as its "Artifacts of Culture Change", and sponsored webcasts for surveyors about resident-centered care in order to ensure that the survey process itself not be a barrier to innovation.

The other positive development is the Nursing Home Quality Campaign, Advancing Excellence. As I mentioned, I have the honor to chair the campaign's national steering committee, which is made up of a coalition of over 30 organizations including provider associations, healthcare professionals, unions, consumer advocates, and representatives from CMS. The members of the steering committee have now been collaborating on the campaign's activities for two years which represents one of the campaign's most noteworthy successes since it has brought us together to focus on attacking the problem of how to improve care in nursing homes, not, as in the past, on attacking each other. I should also note that this campaign is a true public private partnership since it would not be where it is today without the help and support it has received from CMS. While the campaign builds off of Quality First and CMS's Nursing Home Quality Initiative, it has several unique features not the least of which is that

- It is open to all nursing homes, even those not belonging to an association or working with a QIO. So far, almost 7,000 nursing homes have joined the campaign with Arkansas enjoying the distinction of being the first state to enroll 100% of its nursing homes.

- Nursing homes not only must agree to work on 3 out of 8 target areas[1], which were chosen to reflect the QIO program's contract tasks, they have to measure and report back on their progress.
- 49 state level coalitions, called Local Area Networks for Excellence (LANE) have been started. 38 of them are convened by a QIO. They are already showing promise as an efficient way to share good ideas and provide technical assistance to homes across the country.

We believe that this is a campaign on behalf of nursing home residents not only on behalf of nursing homes. Therefore, consumers are being actively recruited in order that we may hear directly what it is residents want. Already over 1,500 consumers have joined the campaign and many attended last year's LANE conference in Fort Worth, TX. Likewise, front line staff are being encouraged to join, and educational materials prepared, specifically to engage them in utilizing evidence based practices because we realize that in the "high touch" setting of a nursing home, quality, ultimately, rests in their hands.

We have been tracking the data now for the first four quarters of the campaign. Results so far are very encouraging: participant homes are improving at a faster rate for the clinical goals than homes which haven't signed onto the campaign. I have included a set of charts with my testimony to show where progress is being made.

In addition to these two examples of change from within industry, The National Commission for Quality Long Term Care, co-chaired by Former Senator Bob Kerrey and Former Speaker Newt Gingrich, which issued its final report in December 2007 laid out a series of recommendations for improving long-term care that merit consideration. Although today's hearing is focused on nursing homes, it is well not to lose sight of the

[1] The target areas are: 1) reducing pressure ulcers; 2) reducing use of physical restraints; 3) improving pain management for long-term residents; 4) improving pain management for short-stay residents; 5) establishing individual targets for quality improvement; 6) assessing resident/family satisfaction with care; 7) improving staff retention; and 8) improving staff assignment so residents receive care from the same caregivers

big picture, since consumers use multiple long-term care services and move between many settings. Therefore, the Commission's recommendations, while organized under the headings of quality, workforce, technology and financing, are applicable across services and inextricably interconnected.

The Commission echoed much of what has been learned through the culture change movement in that it urged that as we consider how to evaluate and monitor quality there is a need to transform the culture of long term care to become "person-centered", not provider-centered, and to broaden the focus beyond just quality of care to the equally important area of quality of life. Surveyors rarely ask residents some of the essential questions in this regard, such as "Do you feel safe, well cared for, valued as a person and comfortable here – that is do you feel "at home"? Are you encouraged to make decisions about your care and do people listen to what you say?"

Already, CMS is taking steps on multiple fronts to ensure that the consumer's voice is heard not just during the survey but during the assessment process as well, since the new MDS-3 will ask providers to gather more information directly from residents, not from other third parties. Likewise, state survey agencies are testing ways to gather better information about quality of life and share it with facilities. An example is the Rhode Island Department of Health's "Individualized Care Pilot" supported under a grant from the Commonwealth Fund, which has been generally positively received by nursing homes in that state since it links quality of life problems identified by surveyors with technical assistance from the state's QIO, a model of collaboration that bears further examination since it removes the surveyors from the role of "consultant" yet offers assistance to providers anxious to address problems.

I would conclude my remarks by observing that there is no silver bullet that, by itself, will make all nursing homes good places to live and to work. There are however, a number of specific steps Congress could take that would support current voluntary efforts while at the same time improving transparency and the regulatory process. They are

5. That the CMS web-site Nursing Home Compare include information on

- Multiple staffing characteristics such as turnover rates for all levels of nursing and administrative staff and use of agency staff as well as the rate of consistent assignment of nurse's aides calculated using a standardized formula; and
- Whether or not a home is participating in the Nursing Home Quality Campaign;

6. That CMS be charged with developing payment methods that would reward nursing homes participating in the campaign and/or achieving results on adopting resident-centered care practices; incorporating those payment methods into Medicare; and working with states to incorporate them into Medicaid;
7. That the QIO program
   - be designated as the appropriate locus for technical assistance to providers rather than the survey agency and that CMS fund and conduct a demonstration project that tests a collaborative role for the QIO with state survey agencies as is being tried in Rhode Island;
   - that future QIO scopes of work continue current funding support for the campaign, which is critically important to the continuance of this successful model for system wide improvement; and
   - direct the QIOs to play an active role in campaign activities including working with the Nursing Home Quality Campaign on both clinical and systems measures needed to promote resident-centered care;
8. That CMS be directed to vigorously pursue its work on using resident input to improve the assessment, care planning and survey processes.

I thank you for your attention and providing the opportunity of addressing the Committee.

Moving to a Higher Level: How Collaboration and Cooperation Can Improve Nursing Home Quality

Charts to accompany written testimony

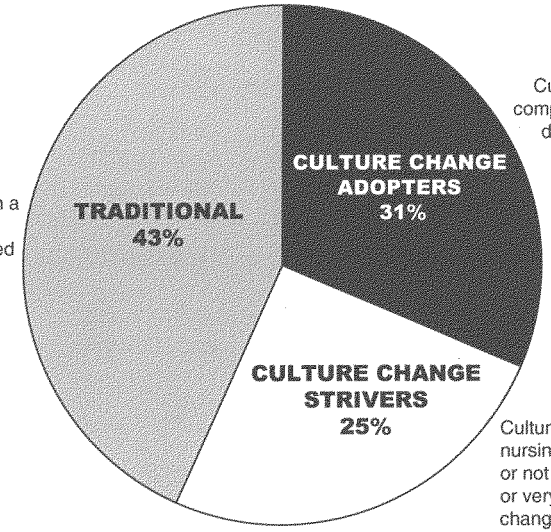
Mary Jane Koren, M.D., M.P.H.
Assistant Vice President, The Commonwealth Fund

U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

May 15, 2008

Figure 1. Nursing Home Adoption of Culture Change, 2007

Distribution of Combined Measures of Facility Engagement in and Leadership Commitment to Culture Change or a Resident-Centered Approach*



Culture change definition* completely or for the most part describes nursing home

Culture change definition* describes nursing home only in a few respects or not at all, and leadership is not very committed to adopting culture change

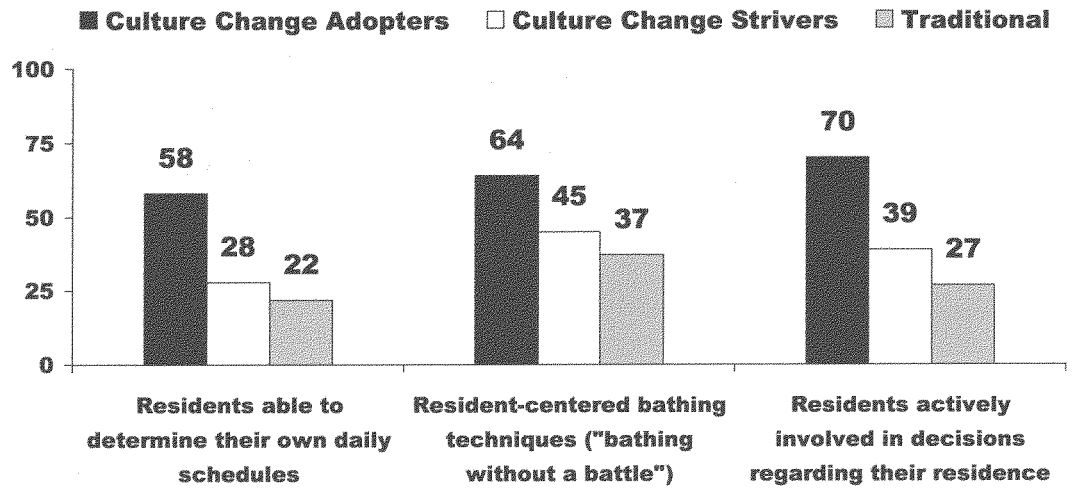
Culture change definition* describes nursing home only in a few respects or not at all, but leadership is extremely or very committed to adopting culture change

*Culture change or a resident-centered approach means an organization that has home and work environments in which: care and all resident-related activities are decided by the resident; living environment is designed to be a home rather than institution; close relationships exist between residents, family members, staff, and community; work is organized to support and allow all staff to respond to residents' needs and desires; management allows collaborative and group decision making; and processes/measures are used for continuous quality improvement.

Source: The Commonwealth Fund 2007 National Survey of Nursing Homes.

Figure 2. Residents' Ability to Determine Their Own Daily Schedules and Make Decisions Varies Widely Between Culture Change Adopters and Traditional Nursing Homes

Percent of facilities indicating they are currently implementing the following initiatives

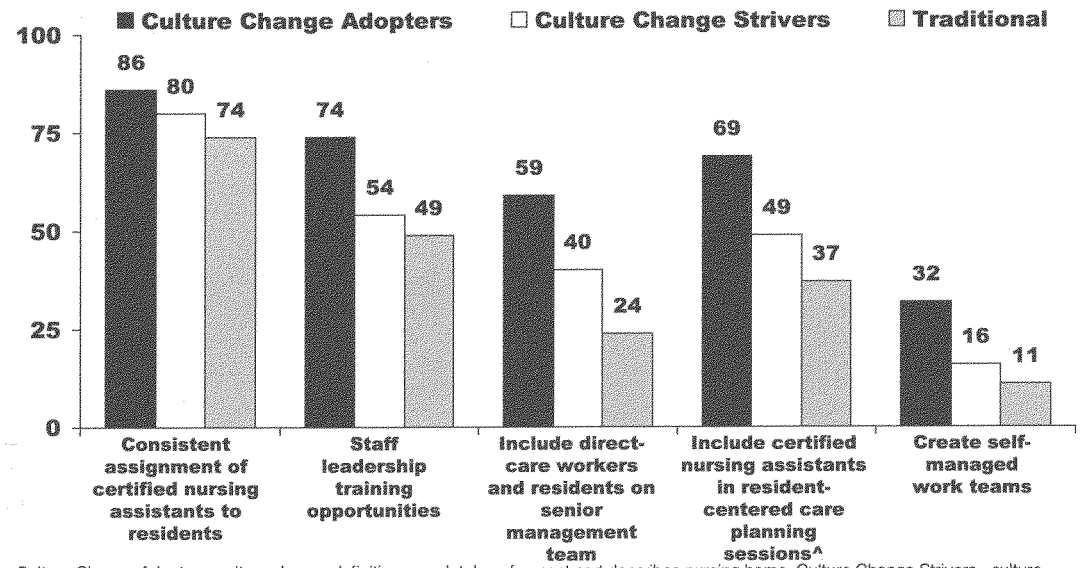


Culture Change Adopters=culture change definition completely or for most part describes nursing home. Culture Change Strivers= culture change definition describes nursing home only in a few respects or not at all but leadership is very/extremely committed to the adoption of culture change. Traditional=culture change definition describes nursing home only in a few respects or not at all AND leadership is less than very/extremely committed to the adoption of culture change.

Source: The Commonwealth Fund 2007 National Survey of Nursing Homes.

Figure 3. Traditional Nursing Homes Lag Behind Culture Change Adopters in Staff Leadership, Empowerment, and Autonomy

Percent of facilities indicating they are currently implementing the following initiatives



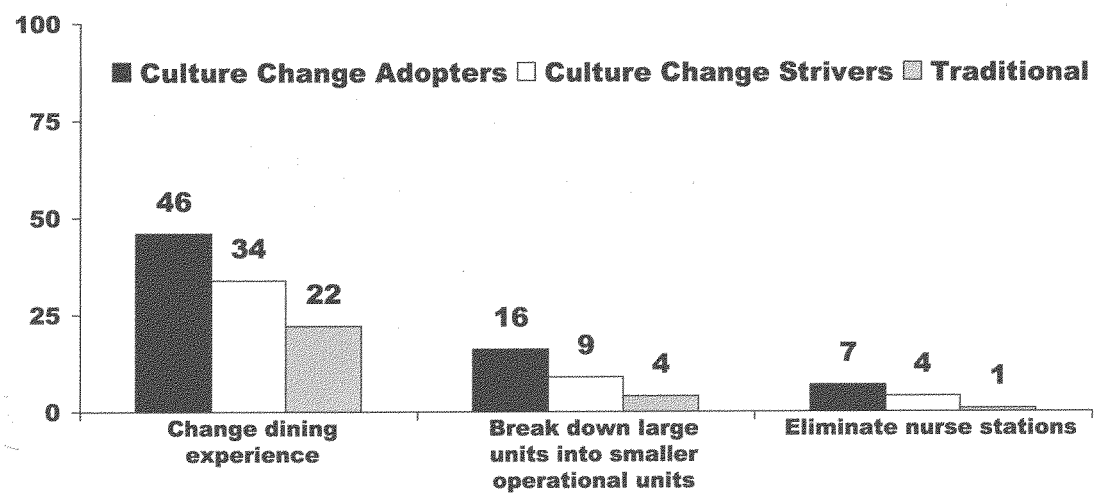
Culture Change Adopters=culture change definition completely or for most part describes nursing home. Culture Change Strivers= culture change definition describes nursing home only in a few respects or not at all but leadership is very/extremely committed to the adoption of culture change. Traditional=culture change definition describes nursing home only in a few respects or not at all AND leadership is less than very/extremely committed to the adoption of culture change.

^ For instance, utilizing the "I Care" or "First Person" approach.

Source: The Commonwealth Fund 2007 National Survey of Nursing Homes.

Figure 4. Few Nursing Homes Have Changed Their Physical Environments, but Nearly Half of Culture Change Adopters Have Altered the Dining Experience

Percent of facilities indicating they are implementing the following initiatives



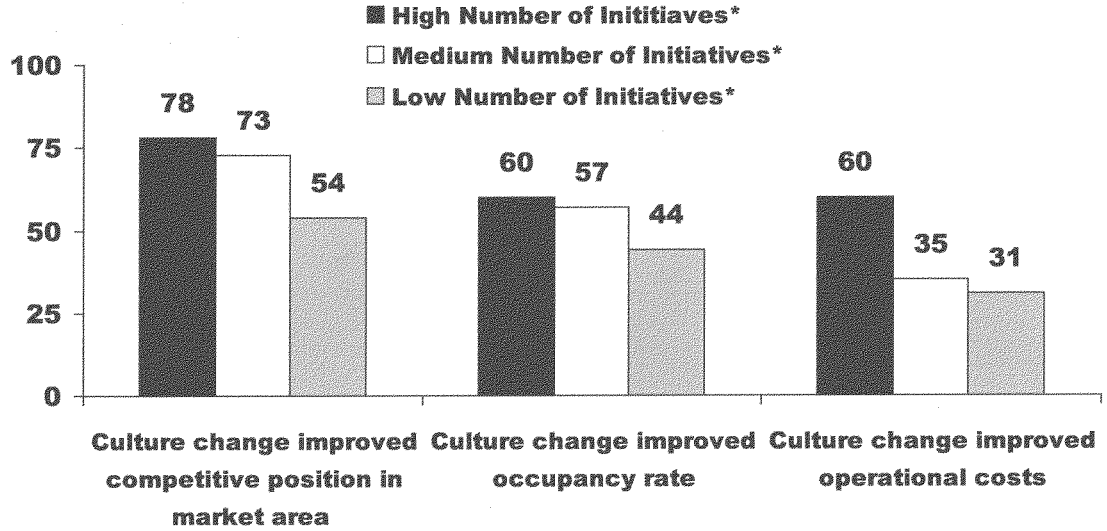
Culture Change Adopters=culture change definition completely or for most part describes nursing home. Culture Change Strivers= culture change definition describes nursing home only in a few respects or not at all but leadership is very/extremely committed to the adoption of culture change. Traditional=culture change definition describes nursing home only in a few respects or not at all AND leadership is less than very/extremely committed to the adoption of culture change.

Source: The Commonwealth Fund 2007 National Survey of Nursing Homes.

Figure 5. Improvements in Business and Operations are Greatest in Homes That Have More Culture Change Initiatives Under Way*

Base: Definition of culture change describes this nursing home completely, for the most part, or in a few respects

Percent of nursing homes indicating that culture change has had the following impacts



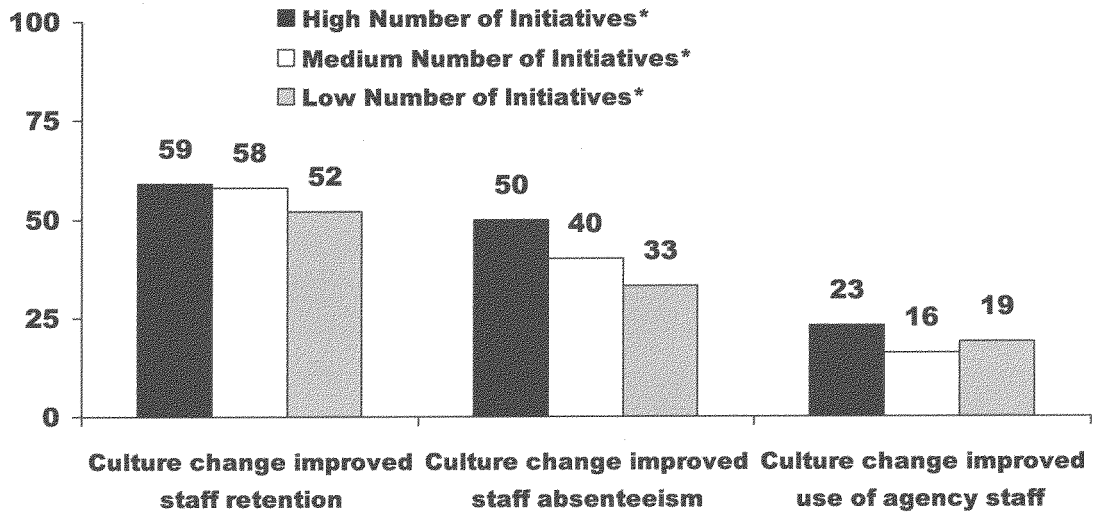
*Respondents were asked whether their home was currently implementing any of eleven different resident-centered, staff, or physical environment initiatives associated with culture change. High=7 or more initiatives; Medium=4 to 6 initiatives; Low=3 or less initiatives.

Source: The Commonwealth Fund 2007 National Survey of Nursing Homes.

Figure 6. Staffing Improvements Are Greatest in Homes That Have More Culture Change Initiatives Under Way*

Base: Definition of culture change describes this nursing home completely, for the most part, or in a few respects

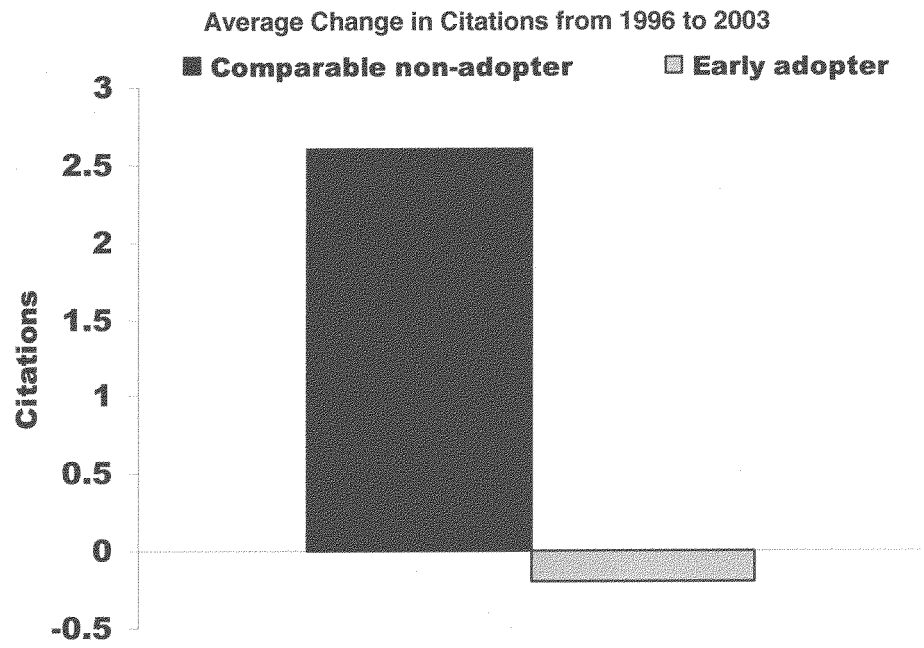
Percent of facilities indicating that culture change has had the following impacts



*Respondents were asked whether their home was currently implementing any of eleven different resident-centered, staff, or physical environment initiatives associated with culture change. High=7 or more initiatives; Medium=4 to 6 initiatives; Low=3 or less initiatives.

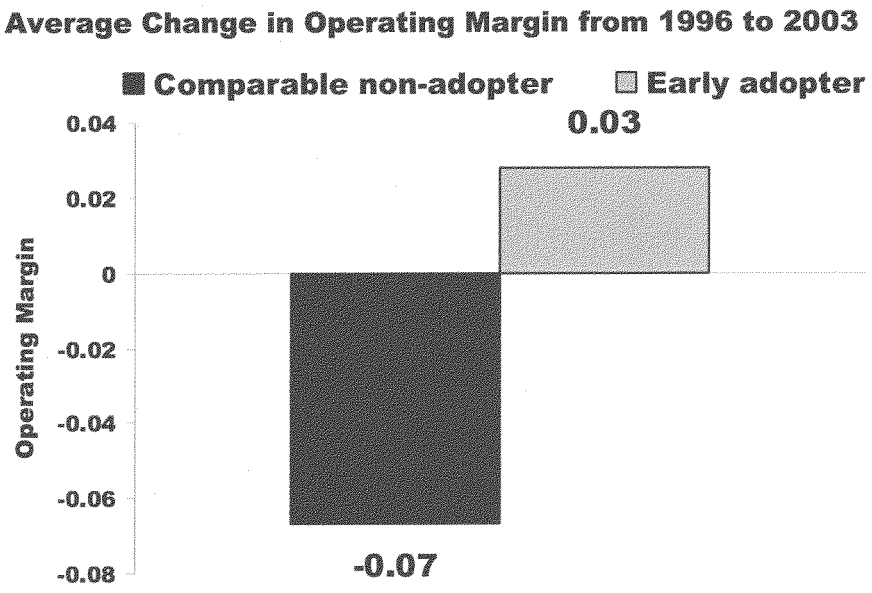
Source: The Commonwealth Fund 2007 National Survey of Nursing Homes.

Figure 7. Culture Change Adopters Receive Fewer Citations for Violations Than Non-Adopters*



Source: *Elliot, A. (2007). *Preliminary Research Supports Nursing Home Culture Change Movement* (available from Pioneer Network, http://www.pioneernetwork.net/news-and-events/PreliminaryResearchSupportsNursingHome.php)

Figure 8. Culture Change Adopters Have More Positive Operating Margins



Source: *Elliot, A. (2007). *Preliminary Research Supports Nursing Home Culture Change Movement* (available from Pioneer Network, http://www.pioneernetwork.net/news-and-events/PreliminaryResearchSupportsNursingHome.php)

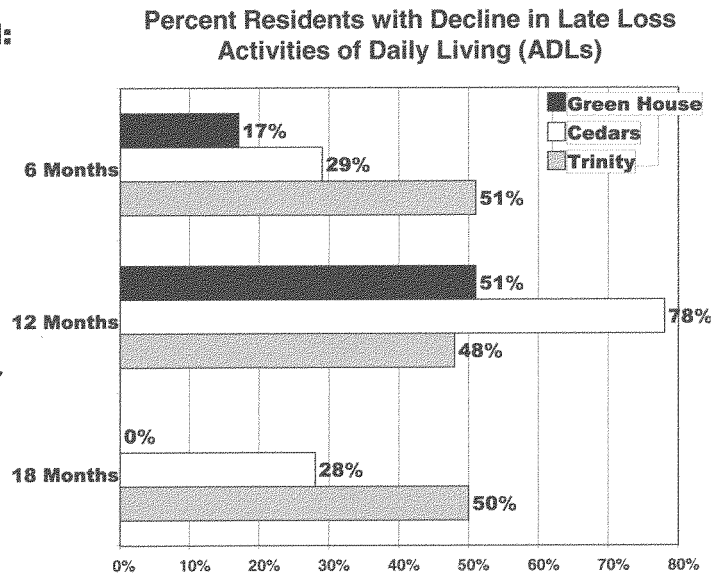
Figure 9. Residents and Staff of the First Green House* Have Positive Outcomes

Green House residents had:

- **A better quality of life**
- **Greater satisfaction**
- **Better or equal outcomes**

Green House staff felt:

- **More empowered to assist residents**
- **Knew residents better**
- **Greater intrinsic and extrinsic job satisfaction**
- **Wanted to remain in the job**



* A Green House is a small group nursing home for 10 residents.
The first one was in Tupelo, MS.
Source: R. A. Kane, T. Y. Lum, L. J. Cutler et al., Resident Outcomes in Small-House Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program, *Journal of the American Geriatrics Society,* June 2007 55(6):832–39

Figure 10a. Nursing Home Participation in the Nursing Home Quality Campaign: State Participation as of May 8, 2008

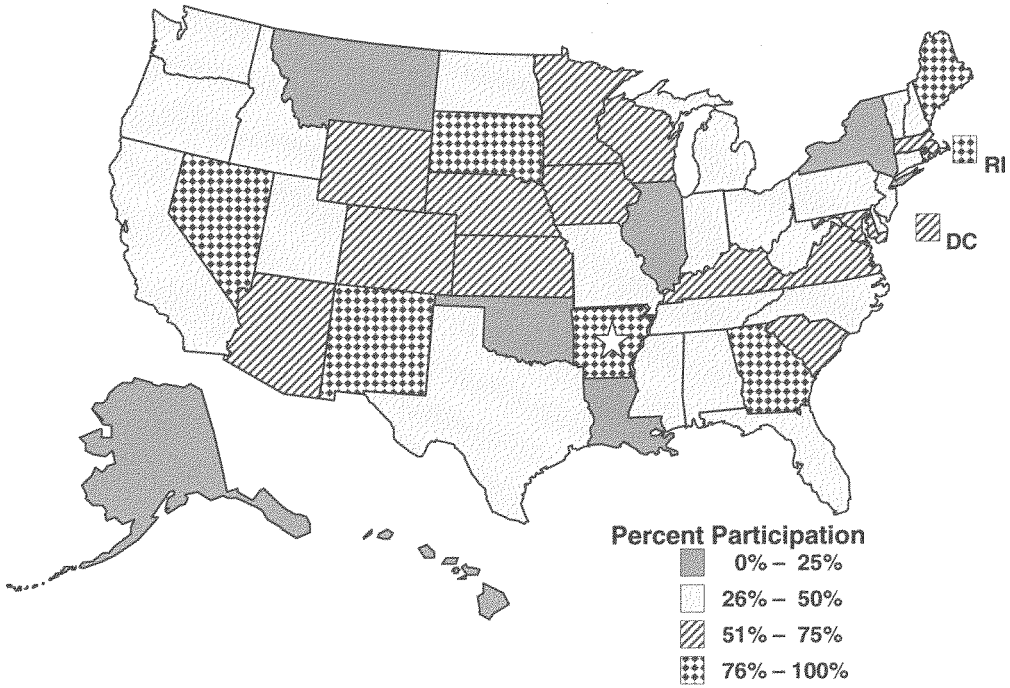
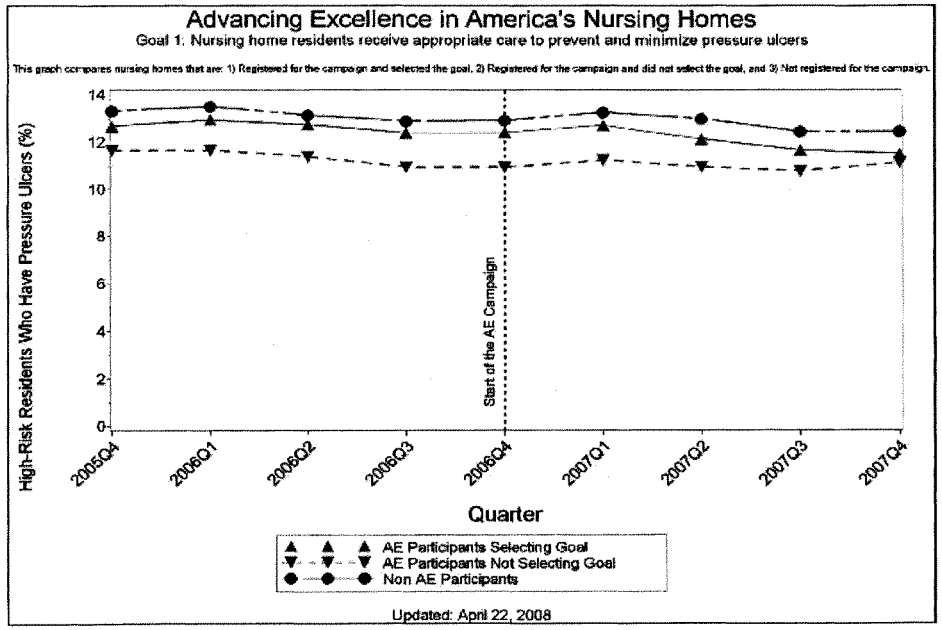


Figure 10b. Nursing Home Participation in the Nursing Home Quality Campaign: State Participation as of May 8, 2008

AK	6.70%	KY	52.70%	NY	18.00%
AL	47.80%	LA	23.30%	OH	44.60%
AR	100.00%	MA	67.50%	OK	22.60%
AZ	62.20%	MD	53.80%	OR	35.50%
CA	25.50%	ME	82.30%	PA	49.20%
CO	69.00%	MI	27.50%	RI	87.20%
CT	38.10%	MN	51.40%	SC	51.40%
DC	60.00%	MO	44.10%	SD	88.20%
DE	47.70%	MS	29.40%	TN	38.40%
FL	32.70%	MT	17.40%	TX	34.30%
GA	96.40%	NC	37.10%	UT	44.10%
HI	17.00%	ND	36.10%	VA	65.30%
IA	50.60%	NE	59.70%	VT	37.50%
ID	35.10%	NH	45.70%	WA	48.30%
IL	20.80%	NJ	30.70%	WI	56.50%
IN	32.10%	NM	91.70%	WV	45.00%
KS	64.20%	NV	81.30%	WY	51.30%

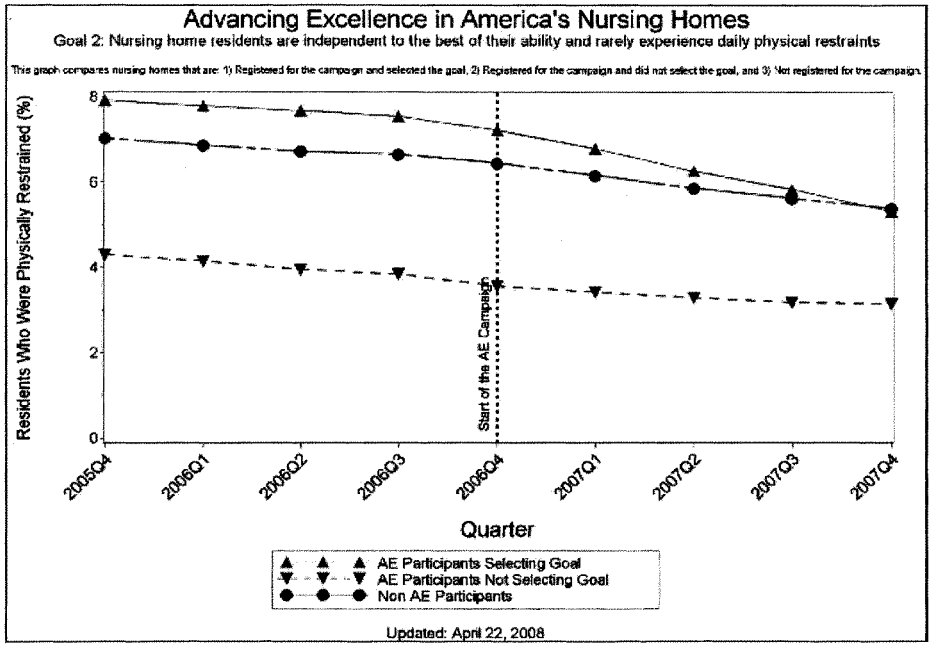
Source: Advancing Excellence in American's Nursing Homes website (www.nhqualitycampaign.org)

Figure 11. Campaign Participants are Lowering Pressure-Ulcer Rates Faster Than Non-Participants



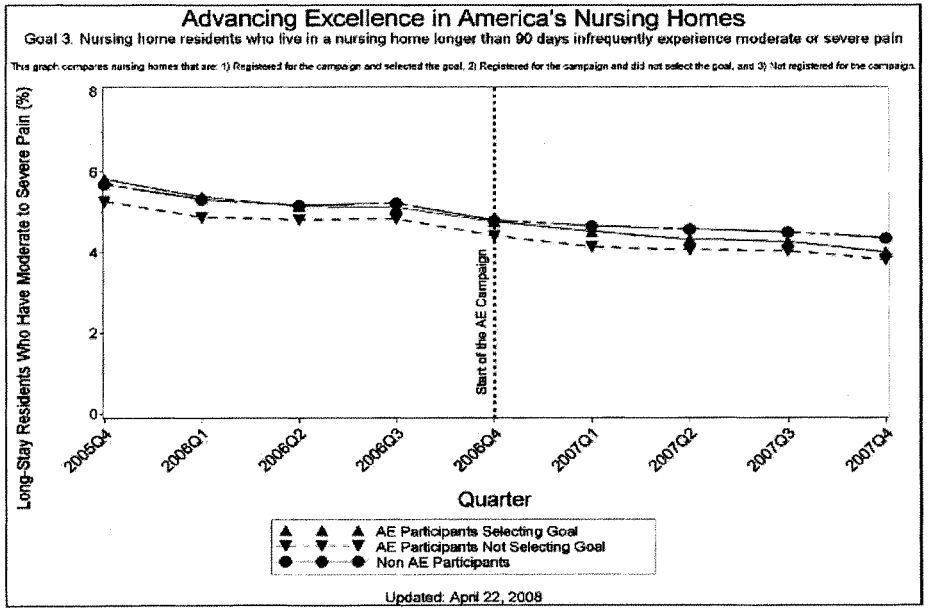
This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 8SOW-RI-NHQIOSC-042008-245

Figure 12. Campaign Participants Are Eliminating Restraint Use More Rapidly Than Non-Participants



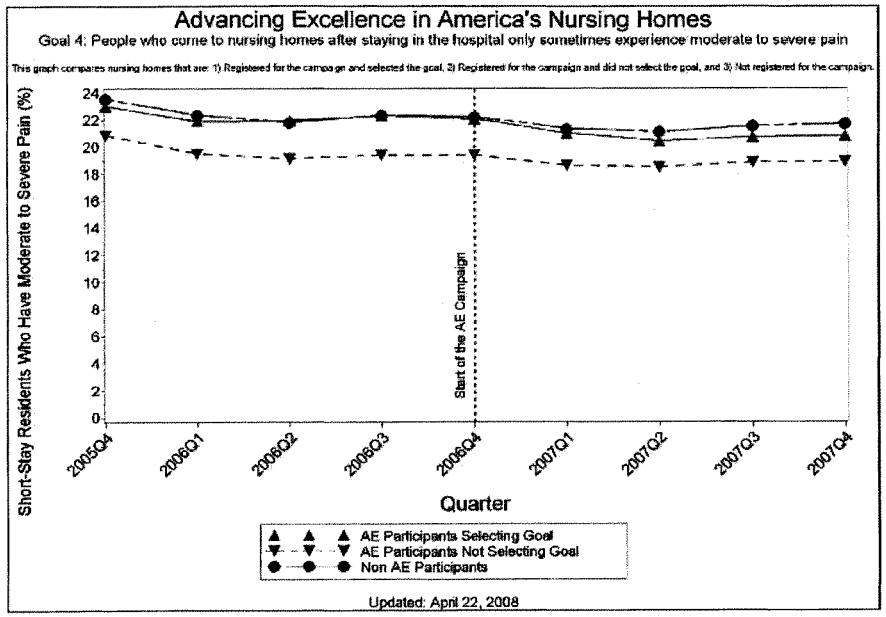
This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 8SOW-RI-NHQIOSC-042008-247

Figure 13. Campaign Homes Are Improving Pain Management for Long-Stay Residents Faster Than Are Non-Campaign Homes



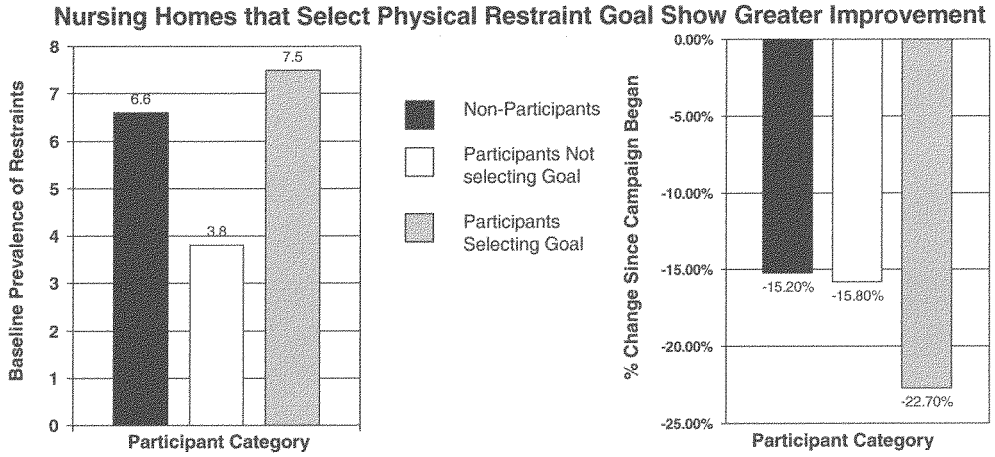
This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. #SOW-RI-NHQIOSC-042008-250

Figure 14. Campaign Homes Are Improving Pain Management for Post-Acute Care Residents Faster Than Are Non-Campaign Homes



This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 8SOW-RI-NHQIOSC-042008-253

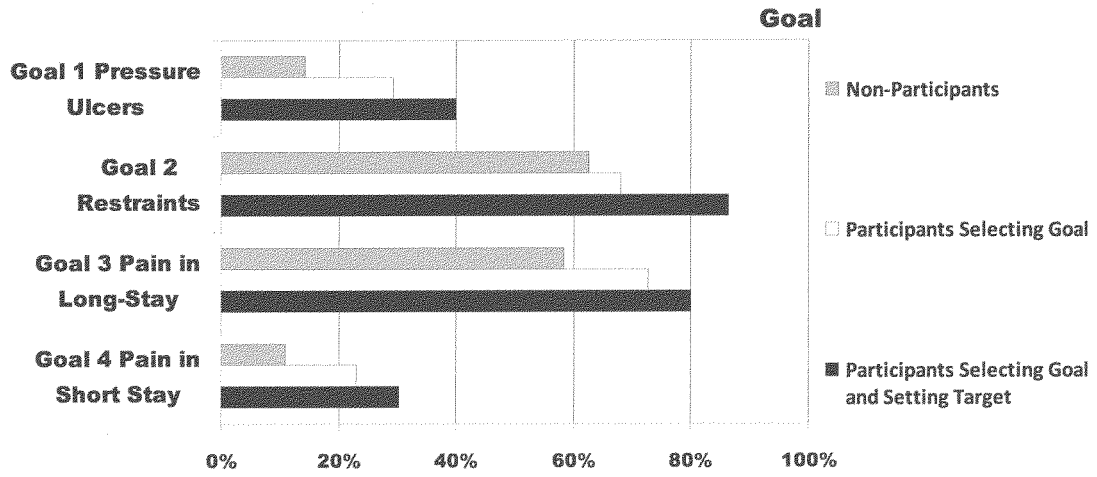
Figure 15. The Nursing Home Quality Campaign Is Showing Results



- 6808 nursing homes (43%) have joined the Campaign*
- Significant representation of for-profit facilities is seen
- Improvements are being seen in other goal areas too
- Given positive trends the Campaign will continue past its original 2 year timeframe

Source: This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health & Human Services. The contents presented do not necessarily reflect CMS policy. Data through one year (four quarters).

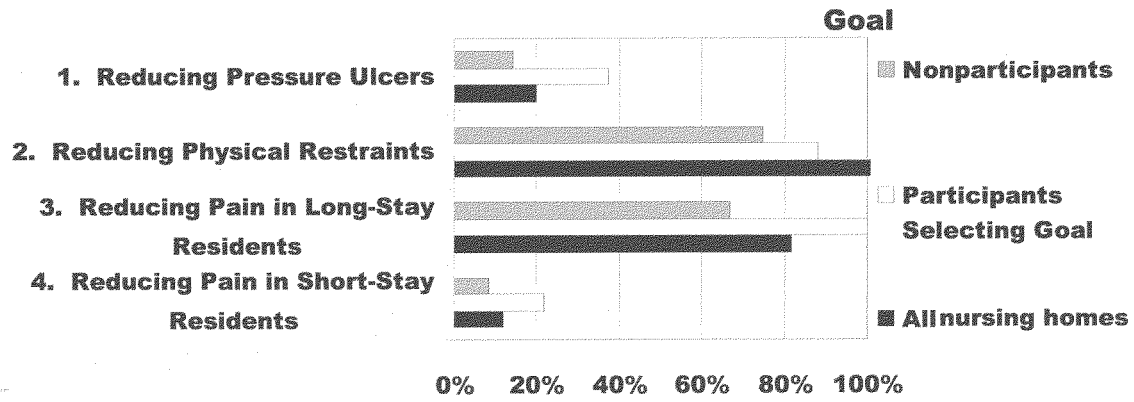
Figure 16. Advancing Excellence in America's Nursing Homes: Progress Toward Goals



Source: This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health & Human Services. The contents presented do not necessarily reflect CMS policy. Data through one year (four quarters).

Figure 17. Advancing Excellence in America's Nursing Homes: Progress Toward Goals, Part 2

Progress Toward National Goal By Campaign Participation: Results 2006 Q3 to 2007 Q4



Source: This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health & Human Services. The contents presented do not necessarily reflect CMS policy. Data through five quarters.

Advancing Excellence in America's Nursing Homes: Summary of Results

- **Ongoing improvement toward five Campaign goals**
- **Goal selection associated with faster improvement**
- **Target selection associated with faster improvement**
- **Goal 2—reducing physical restraints—achieved national target for:**
  - **Objective A, restraint use at or below 5% (at 4.9%)**
  - **Objective B, 50% of homes with restraint use below 3%**
- **Goal 3, reducing pain for long-stay residents: near national target for:**
  - **Objective A, national average at or below 4% (at 4.2%)**
  - **Objective B, 30% below 2% (~35% have met threshold)**

Source: This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

Advancing Excellence in America's Nursing Homes: Summary of Results, Part 2

- **The number of frail nursing home residents is on the rise**
  - **More short-stay residents**
  - **More residents at high risk for pressure ulcers**
  - **→ Challenge for achieving absolute reduction in numbers (Objectives C and D for all goals)**
- **Majority of facilities have not set targets**

Source: This material was prepared by Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

Mr. STUPAK. Thank you. Thank you all for your testimony. We will begin questions.

Dr. Kramer, I understand you are one of the authors of the report commissioned by CMS titled "Improving Nursing Home Enforcement" and that report was completed about March of 2007?

Dr. KRAMER. Correct, yes.

Mr. STUPAK. And it has not been made public yet by CMS?

Dr. KRAMER. I understand that, yes.

Mr. STUPAK. Do you know any reason why it would not be made public?

Dr. KRAMER. I actually do not know the reason why it is not public.

Mr. STUPAK. In this report, it shows that the survey system as it is currently administered significantly underestimates the deficiencies present in most nursing homes. In fact, there is a GAO report out that basically echoed those findings. The report shows only about a quarter of the deficiencies practiced are detected by the surveyors. Why is that?

Dr. KRAMER. Well, that report was based on going to nursing facilities and using the methods that are used in the Quality Indicator Survey concurrently with surveys. This was done in 26 facilities, and one of the things that was very evident is that without the structure of something like a Quality Indicator Survey, the surveyors are faced with this morass of regulations that they are trying to interpret. They have interpretative guidance to do this, but there is no structure to follow. And in the end, the documentation that comes out of it is not strong enough for them to trust. The QIS approach that was used in these case studies is a much more methodical, replicable process.

Mr. STUPAK. You have QIS and then you have other, the current way they do the surveys. I take it the current way of doing the surveys, as I have heard from Mr. Pruitt, Dr. Koren and others, that it is basically more subjective than the QIS?

Dr. KRAMER. Yes, that is what the case studies showed and that is what——

Mr. STUPAK. Is that the inconsistency then in enforcement depending on the——

Dr. KRAMER. Well, the enforcement is at the end. But enforcement actually can get watered down if you don't have really clear evidence of the problem and good documentation. And the problem is that in the traditional survey process they invest a lot of resources in but because that structure is not there, they don't always get all the information that is needed.

Mr. STUPAK. On the QIS, again, that CMS commission and evaluation, that was completed in December—do you know of any reason why that has not been released?

Dr. KRAMER. I don't know why that is not released.

Mr. STUPAK. Are there any independent conducted surveys that document the superiority of the QIS over the current survey system?

Dr. KRAMER. Independent—like what are you——

Mr. STUPAK. Well, other than the one that you were commissioned to do to complete the survey for CMS, is there anything else that has taken the same factors of the Quality Indicator Survey,

the QIS, and to show that it works better than the current system we have?

Dr. KRAMER. OK, so the evidence we have—the case studies are one example. We went in and used QIS methods and then the surveyors used the traditional process, and there were pretty dramatic differences in the problems identified. The other evidence is what you hear from the surveyors. They all say it is more consistent, more objective. That is why the States are lining up to do it. And what is very interesting is that there is another group that is starting to support it and that is the provider community because they also find it more objective. Even though there are more deficiencies in QIS and in different areas and in some new areas, there is support there among providers.

Mr. STUPAK. Dr. Koren mentioned the Advancing Excellence program that nursing homes are voluntary doing. Are you familiar with that program?

Dr. KRAMER. I am familiar with that program.

Mr. STUPAK. How does that relate to the QIS?

Dr. KRAMER. At this stage, because QIS is not rolled out nationally, it is not integrated with that Advancing Excellence activity.

Mr. STUPAK. Could it be integrated?

Dr. KRAMER. It could be fully integrated and broaden that initiative so that you could target the full range of the Code of Federal Regulations instead of more narrowly targeted areas.

Mr. STUPAK. You mentioned $20 million to get the other States into it. Were those the States that were first selected as the pilot States or are you talking about nationwide?

Dr. KRAMER. We could do it nationally for $20 million. The pilot States are in it. There are three more being rolled out this year. With $20 million, it could be rolled out to every State in the country.

Mr. STUPAK. Dr. Zimmerman, you mentioned your group had looked at 1,000 nursing homes. Is it fair to say that CMS's regulatory framework is not equipped to address the contemporary challenges posed by chain ownerships that we heard about in the earlier panel?

Dr. ZIMMERMAN. Well, I think that the regulatory process as it currently exists is to some extent limited by the fact that the contracting agencies that actually carry out the surveys are the State survey agencies, they are State agencies, and to my knowledge, there has been very little thus far. Now, I am not privy to a lot of the information within CMS so I would defer to Administrator Weems on this, but to my knowledge, there hasn't been a lot of activity that enables survey agencies to cross State lines, and so if you have a corporation that has facilities across a variety of States or regions, it is somewhat difficult within that regulatory community to be able to do this. So that is one issue. The other issue is that I think that the internal compliance function within corporations as well as looking at the systems of care is something that the regulatory process right now is not that equipped to do. That is not to say that there is not a prominent role for it but I think it has limitations in terms of looking at systemic changes that can be brought about.

Mr. STUPAK. As we look at these private equity firms, and I think in my opening I said more than 50 percent of the nursing homes now are owned by private equity firms, I got the distinct impression in listening to the earlier panel that while the nursing home administrator who would be there when the surveys are going on would like to do the right thing but who do they turn to to get the resources to do it or to make those policy decisions? In your surveys, did you see that when you did a nursing home that was locally or privately owned as opposed to those that are part of a chain in a private equity firm?

Dr. ZIMMERMAN. Well, we certainly saw the phenomenon of facility leadership wanting to engage in more resources. This phenomenon was not universal but we saw quite a bit of it. I don't—I am not prepared to say that that was systematically different between private equity firms and other organizations, Number one, and Number two, it is also true that in some cases, the reversed phenomenon took place, which is that there were district and regional folks within a corporation that wanted to engage in quality initiatives and there was some resistance. So this is a complicated problem.

Mr. STUPAK. I have one last question and then I will turn to Mr. Shimkus. Dr. Kramer, you said $20 million for full funding the national rollout of the QIS. You also said industry is now supporting the QIS. Has there been any discussion about maybe having industry help provide some of that $20 million to roll out the program?

Dr. KRAMER. I haven't been privy to those discussions but——

Mr. STUPAK. I thought I would throw it out there.

Dr. KRAMER. That is an interesting——

Mr. STUPAK. How about you, Mr. Pruitt? Do you think industry should provide some of that $20 million?

Mr. PRUITT. I am not aware of any discussions within our association to offer to help defray the cost.

Mr. STUPAK. Do you think it is a good idea?

Mr. PRUITT. I believe that we need to address our current funding issues before we spend our resources on rolling out that initiative.

Mr. STUPAK. Dr. Koren, do you want to say anything on that?

Dr. KOREN. No.

Mr. STUPAK. OK. Mr. Shimkus for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman. The $20 million, in the numbers that we deal here in Washington, it didn't seem like an awful lot of dollars. It is interesting how we do it and how it gets applied. This is a very good hearing and I appreciate all the testimony.

Mr. Pruitt, you operate in three States. Is that correct?

Mr. PRUITT. Four States.

Mr. SHIMKUS. Four States. Do you know—the question I had asked earlier on the—you may not see it because you just see the reimbursement from the State on Medicaid services, but do you know the individual States' FMAP from the four States that you service?

Mr. PRUITT. I have a general idea but I would be afraid to quote those FMAP statistics to you. I can get that for you at a later date.

Mr. SHIMKUS. It would just be interesting in your service area whether you have one 50/50 State, one 60/40, one—I really dislike this FMAP, and when we talk about the reimbursement for services and care, it is just—if you can get funded, it might help people do cost shifting. But I also observed, I think all of us who have had loved ones have observed the change in care and the continuum of care, as I mentioned before, and I think the continuum of care probably can help. Those who are moving to this continuum of care are probably more—I shouldn't just be generalizing but it is our own experiences as Members of Congress, we go into nursing facilities, we visit all these different aspects, and then—but the newer ones—what I want to focus on is the debate now is this QIS and what the industry is doing on its own, and there was a percentage of 43 percent, Dr. Koren mentioned 43 percent participants. The debate is, how do you get the 57 percent to get to 100 percent and do you do it regulatory? And then the debate is, if you have the information, then how do you follow up the ladder? If it is voluntary, then where is the ability of government to step in? So why don't you answer that question? I think I want to go to Mr. DeBruin for hopefully a segue into it after I get—how do we get the other 57 percent to be involved?

Mr. PRUITT. The Advancing Excellence campaign has been a tremendous success, and as was mentioned earlier, it is 2 years old. During that time, we have seen participation dramatically increase. From my own organization's experience, all of our facilities participate in Advancing Excellence. The American Health Care Association has publicly stated that it encourages all members to participate in the campaign. One of the ongoing industry efforts is, we are collecting quality statistics about our members and where there are deficiencies in practices, we are offering resources to help them improve.

Mr. SHIMKUS. Before I go to Mr. DeBruin, Mr. Zimmerman, how does this program affect the internal compliance issues that you've discussed or does it not? Is there a connection? Have we got three different things going in different directions?

Dr. ZIMMERMAN. Well, I don't think they are completely independent at all. I think that the Advancing Excellence campaign is really an initiative, a quality improvement initiative that has taken on aggregating importance throughout the industry and I think that is very important. It can be very complementary to internal compliance functions. Frankly, internal compliance is just good management and so if you are engaged in good management, you are going to look for quality improvement programs as well. I would suggest that what we need to do, as any good manager would do, is to make sure that we validate that what we are being told in terms of some of the outcomes, in terms of some of the processes is happening as we are told it is happening, and I am not suggesting that we need to do that because we don't automatically believe somebody but it is just good oversight and management to make sure that we validate these quality improvement efforts. So I think they can be very complementary.

Mr. SHIMKUS. And what is the number of nursing homes that are involved in internal compliance issues?

Dr. ZIMMERMAN. Well, I am aware—I am not sure I have this correct but I think that with respect to the corporate integrity agreements, there probably are anywhere from 1,000 nursing homes to 1,200 nursing homes that have been part of corporate integrity agreements with the Office of the Inspector General. The OIG also has corporate compliance agreements with probably another 1,000, I would bet, but at any rate—so that would represent a little over 10 percent of the industry.

Mr. SHIMKUS. The mandatory versus voluntary, what about voluntary?

Dr. ZIMMERMAN. I am not actually that familiar with the voluntary ones because we don't get involved as outside monitors in this process, so I would have to defer to actually Mr. Morris, who was on the previous panel.

Mr. SHIMKUS. Mr. Pruitt, do you have a compliance program?

Mr. PRUITT. We have a voluntary—well, before our purchase of the Monks Corner facility, we were not required to have a compliance program. Once we purchased that facility, they wanted us to maintain the quality of care compliance program. That was 8 months ago. Prior to—since 2002, we have had a voluntary compliance program that is extremely effective within our organization. We have used it to improve quality and ensure that we are in compliance with all Federal laws and regulations.

Mr. SHIMKUS. How does that help you? I mean, you said it helps you. How?

Mr. PRUITT. We have a corporate compliance officer, who is also trained in Six Sigma. She has a staff that analyzes our data. When there are issues, we identify them internally and disclose them when necessary to government authorities. This, by being proactive, we are able to catch problems before they become a large event in our corporation.

Mr. SHIMKUS. Thank you, and I have been meaning to get to Mr. DeBruin. The first panel dealt with Connecticut and the sad state of affairs, so what I am trying to do is connect the dots and I am trying to say OK, we need to have information. We have got Dr. Kramer's system that sounds like it is pretty good. We have got industry working on its own. The State still has a major role to play with licensing and the attorney general, and we saw in the Connecticut issue, that there was a problem identified and there was a couple steps that had failed within the States. My issue is, how much—if we are going to re-look at this, we also have to look at the ability of the States to carry their share of the load as far as laws on the books to help us in this process and segue more of this information into that arena. Would you agree?

Mr. DEBRUIN. Absolutely I agree. I think States obviously play a major role, I think. I agree that voluntary programs are very important. In fact, the Advancing Excellence program is a program that we as a union are very involved in and support and I think that the questions you are asking go right to the heart of the issue here, which is there are many of the providers—most of the providers that our union represents are very good providers that do volunteer and do very good work to comply. The problem is with those who don't and that, as Mr. Morris testified earlier, based on recent surveys and information that is available, if 20 percent of

the nursing homes in this country are actually putting nursing home residents at risk by not being involved in these voluntary programs and not complying, that is—of 1.5 million residents in nursing homes, that is 300,000 people, and that is really, I think what regulation is needed for, is to hold those providers accountable.

Mr. SHIMKUS. And again, I will just end up by saying because of the way the industry has changed in rural small town America, there are still probably in the model of care from 20, 25 years ago where they haven't done this expansion or capital because the numbers are there not to, and it is going to be interesting to see how we segue because they are needed. That is why I am so hot on the FMAP, and I will end on that.

Mr. STUPAK. Mr. Walden for questions, please.

Mr. WALDEN. Yes. Thank you very much, Mr. Chairman. I want to take issue with my colleague from Illinois, who suggests that we are all headed toward the nursing home. I have no plans to run for the United States Senate.

I want to touch on a couple of issues from a serious standpoint now, because I have actually spent more time in the nursing home in the last year than I would have liked. My brother was nearly killed in a motorcycle accident in August. My mother-in-law actually just passed away this morning. And so there are some real-life issues I think many of us deal with and have questions with and some of them, frankly, are the stupid regulations that are on the books today, and I wish I could have been here for the earlier part of the panel but I wasn't able to. In my brother's case, he is now fortunately mostly recovered. He went into a veterans' nursing home, which was terrific except that there is a regulation that says you can't put up the little bar there on the side of the bed because it is considered a restraint. So you know what they did? They lowered the bed as far as they could to the floor and put a plastic mat out with a sensor so when he would roll out of the bed, he would roll onto a mat, because there is a regulation or a law that says oh, no, you can't restrain somebody like that. I mean, that is pretty darned stupid out there, and I just wonder, we all talk in these terms of quality assurance and yada, yada, yada. I want to get to the real-life problems that you all are dealing with and that we as family members deal with. And then I read about, the issue here is the State inspectors apparently aren't doing their jobs, and I am wondering, do we need a new law or do we just need to bring the States up short and say do your job, do the inspection, report back.

The other issue, and I know this came up in earlier discussion about access to ownership. I was a licensee of the Federal Communications Commission for more than 20 years. We had to file annual ownership reports and I believe those were available on the Internet. How hard is this with today's technology to do that? And if there is a change in ownership, you are required to file or you don't get paid. It is real simple. And so it just strikes me, there are some of these things that don't make a lot of sense, and I have seen really good treatment and I have seen some real bonehead mistakes. My mother-in-law was gluten intolerant, allergic to wheat. Two mornings in the same week they tried to feed her Cream of Wheat for breakfast. They ground up pills that were time-release

because she was having trouble swallowing. We ended up hiring private care to be in the room to make sure those things didn't happen.

So, I mean, I have seen all sides on this industry. I have also seen when my mother was in her final years, a decade or more ago, that the staff was so burdened with the paperwork requirements of the government that they didn't have time to do the care they were trained to do. And so I don't want to see us go to the point where we just add a whole new layer of rules and regulations, some of which, as I have said, don't make any sense to me as a layperson here. I talked to a nursing home administrator who manages some homes that deal specifically with those who have mental deficiencies and they are required under the rules in this particular State, not my own, that all those people have access to anything anybody else has access to, and he said, that means if we have drain cleaner, they can get access to it and we can't lock it up. I mean, it just makes no—there are some commonsense things here. We cannot micromanage. We have to have responsible people and then we have to have quality assurance programs that enshrine that commonsense piece.

Can any of you explain to me why we would have a rule on the books that says if somebody is rolling out of bed repeatedly, you can't have one of those bars you put up like you do if you have a baby? Dr. Kramer?

Dr. KRAMER. Why don't I talk about it?

Mr. WALDEN. And who is doing something about it?

Dr. KRAMER. So here is the dilemma. There is a code of regulations.

Mr. WALDEN. Oh, I know.

Dr. KRAMER. And that code of regulations are quite nonspecific, and the issue with physical restraints is, there are cases where somebody is truly at risk and there is no other way but some form of a system for helping them preventing falls. But there are all sorts of ways of doing that, and the trick is, how do you apply these regulations in individual cases. And that is why you need a structured process. You mentioned that you don't think the surveyors are doing their job.

Mr. WALDEN. No, I am just saying what is in the press reports here and——

Dr. KRAMER. Well, the thing about the surveyors is, I don't think in the current process they have the tools always to do the jobs and help them work through the decision process in order to apply those many regulations. Those regulations make a lot of sense in many, many cases and you just have to figure out how to apply those regulations to individual cases.

Mr. WALDEN. Somewhere, though, we have lost common sense and there has to be a threat of the person running the operation that says if I do anything, I am going to get sued or I am going to get fined. Tell me then why they couldn't put, or I was going to go put the bar up on the bed. I mean, every hospital bed has one of those.

Dr. KRAMER. That actually doesn't have the impact that everybody thinks it is going to have in terms of prevention because there

is some danger associated at times with those bars. People can get——

Mr. WALDEN. I could give you two pages to tell you how many times he rolled out on the floor.

Dr. KRAMER. Well, that is a problem. He shouldn't be rolling out of bed.

Dr. ZIMMERMAN. Actually, let me supplement what Dr. Kramer says.

Mr. WALDEN. He wasn't injured. They had a nice pad and a little device that went off every time he rolled out.

Dr. ZIMMERMAN. Our monitors have seen at least 50 cases in which people have strangled themselves in side rails. They have seen cases in which people have climbed over the side rails because they were in danger of falling, and they could get over the side rails just as easily as they could fall without the side rails. So that is the reason for the——

Mr. WALDEN. You can't redesign side rails? We have done cribs, redesigned those.

Dr. ZIMMERMAN. That is exactly right. There are ways to design restraints that would keep somebody from falling out of bed without having it be side rails, some of which can kill people. So I think that is what Dr. Kramer is saying. There is common sense that needs to be provided, and the application of a rule which is blind to the context in which it is being applied is agreed to be bad.

Mr. WALDEN. That is the issue.

Dr. ZIMMERMAN. And yet there are ways in which we can do this without having to put somebody in the kind of jeopardy that we have just discussed. So yes, there is a solution to your problem.

Dr. KRAMER. And every one of those things have a risk——

Mr. WALDEN. Of course they do.

Dr. KRAMER [continuing]. Associated with them and so the application of all these regulations has to be done with care, and side rails turns out to be a reasonable regulation. The issue is to approach it and make sure that people aren't falling out of bed. There are other ways to approach that kind of issue and——

Mr. WALDEN. Mr. Pruitt?

Mr. PRUITT. If I can answer from a provider's perspective, AHCA has encouraged the creation of a commission to examine issues such as that. The restraints is a quality measure that we do measure on a periodic basis but all of the quality measures need to be examined. For instance, high-risk pressure ulcers is one of the Advancing Excellence initiatives that is publicly tracked. What is an issue with this indicator is that you don't count the indicator on the initial assessment, so if I met a patient with a high-risk pressure ulcer on day 5 when I do my initial assessment, that doesn't count against me. But if I haven't healed that pressure ulcer by the 14-day assessment, it goes on my record as a deficient practice if you measure that in terms of quality indicators. AHCA believes we need to examine quality measures and come up with a smarter way of looking at the measurements of quality.

Mr. WALDEN. Anybody else?

Thank you, Mr. Chairman.

Mr. STUPAK. Thank you.

Let us go another round with this panel here. It is a good panel. We have had some good discussions.

Mr. Pruitt, if I was going to go into the nursing home business and we have these private equity firms moving in there, if you take a nursing home, how much should I be able to expect on return on my investment? Is there a rule of thumb that you look at?

Mr. PRUITT. There is no real rule of thumb. I can only speak to how we look at a facility when we look at purchasing one. We look at the long-term value that it can create, and a lot of it has to do with our social mission as well as how we feel that will fit into our model of care, which also involves community services. So we look at a center-by-center basis. We plug in the staffing levels that we would provide, which typically is more than the seller provided, and we look at our ability to operate that center and achieve the type of care we want to achieve.

Mr. STUPAK. The private equity firms, Carlyle, and I think Mr. DeBruin mentioned they got a $5.5 billion return they have to make up. When you buy a number of centers, as you said, there has to be some kind of expected return on it, otherwise you wouldn't do it, and especially private equity firms who are in the business of making money. So I am just a little bothered with that.

Let me ask this question. The Advancing Excellence, does it cost more to implement it or is it commonsense things you should be doing and you make up for deficiencies elsewhere within the home and you eliminate those deficiencies so in the long run it is profitable?

Mr. PRUITT. What Advancing Excellence has allowed us to do is concentrate our resources and moving certain indicators. In my opinion, it does not cost more to implement the initiative. In fact, it saved money on the back end. If we can identify problems and as an industry share best practices, we are more than likely to decrease the cost of care. If we can prevent a wound, it is going to be cheaper than if we have to treat a wound, and I believe Advancing Excellence encourages us to do what is right in the first place.

Mr. STUPAK. Well, then, Dr. Koren, why wouldn't more centers come into your Advancing Excellence? We are at 43 percent. I think Mr. Shimkus said what about the other 57 percent. How do we get them there?

Dr. KOREN. Well, remember, we have only been doing this now for less than 2 years, and it is a voluntary effort and I don't think you will ever get 100 percent of people to volunteer for something like this. But what we are hoping to do is, we are hoping to reach out to people and start to show the advantages of improvement. As Mr. Pruitt said, one of the things, one of our targets is trying to increase staff retention. The cost to a nursing home of high staff turnover is profound, and here is a way that you can both improve quality and save costs, and we are trying to show those kinds of things so that we have people come into the campaign and kind of join it. We are going to continue it. We are looking to use our local area network to continue to recruit.

Mr. STUPAK. So basically your quality program here, your Advancing Excellence, while there can be some beneficial, as Mr. Pruitt said, it is easier to prevent the wound, the open wound as opposed to treat it. That is the incentive, right, better quality care?

Maybe you can cut down your costs. But there is nothing mandatory, there is no enforcement. If I am in it, I am participating and I think this is just too much a hassle and I drop out, there is no mechanism or no punishment for doing that, is there?

Dr. KOREN. No, this a completely voluntary campaign, and so it has that limitation as well as that advantage.

Mr. STUPAK. All right. Let me ask this question. It came up in the last panel, besides ownership, one of the things that they were talking about was a database, and Mrs. Aceituno, who testified about her husband there, she felt like she didn't get enough information about the quality of care that was provided by that center that her husband was at and she said if there is one thing she wanted to see was a more comprehensive report or patient information before you put your loved one in a nursing home or a center. Any problem with that, like identifying who the owners are, what are your rights before you enter into a center? Do either Mr. Pruitt, Dr. Koren or anyone else want to comment on that?

Dr. KOREN. I think that one of the big problems, first of all, as we know, the nursing home compare site just has a very limited amount of information and a lot more could be put on there in order to help people make the decision. But I think we should also realize the discharge planners, and most people who end up in nursing homes come from a hospital, don't tell people to go look at it. So one of the things we have got to do is work collaboratively with the hospital side to ensure that people know where to go to get information.

Mr. STUPAK. How about online information? We are suggesting that be done in our Food and Drug bill that we are moving on so someone—you would know where to go to have that information as to the ownership, what is its quality assurance or Advancing Excellence, if they are a member of that program or not. Just trying to get more information online, would that be appropriate?

Dr. KOREN. I think it would be critical. I had to choose a nursing home for my father, and while I was able to go to Nursing Home Compare because I knew about it although the discharge planner didn't tell me about it, it provided enough information that I knew what nursing homes were in his area and I could start to narrow my search. But it certainly didn't provide enough information to be able to go and say I know this one is a good one and this one isn't.

Mr. STUPAK. So you would have no objection to an online program or some universal database nationwide?

Dr. KOREN. No.

Mr. STUPAK. Mr. Pruitt?

Dr. ZIMMERMAN. Mr. Chairman, one other point about this is that——

Mr. STUPAK. Sure, and then I will go to Mr. Pruitt. Go ahead, Mr. Zimmerman—Dr. Zimmerman. I am sorry.

Dr. ZIMMERMAN. The issue—two other points about the Nursing Home Compare and that information. First of all, we actually were engaged in a project that was funded by the Commonwealth Fund to engage folks in using some of this information, using the data on the quality indicators and the deficiencies, et cetera. It turned out that one of the most difficult groups to engage in this process was hospital discharge planners, and it is not clear even to this day

why it was somewhat difficult to get them to be engaged but I think in fact they probably had a lot of other things to do and felt that they might have had sufficient information. So we have to make sure that those professionals who are responsible for the reference to nursing homes are going to be using this information.

Secondly, I think one of the opportunities we are really missing in this information is that it is not just the selection of the nursing home that means that you can use this information, because as several of you have mentioned and several panel members, frankly, the selection of a nursing home is very limited. It is extremely limited in rural areas. There just aren't that many options, and you have a very traumatic situation. What I am talking about is using this information after the selection to make sure that you can monitor how well the nursing home is taking care of your mother, which I think would suggest a somewhat different way of putting the information together.

Mr. STUPAK. Mr. Pruitt, you had wanted to say something?

Mr. PRUITT. I would mention on the transparency aspect of our industry, many corporations including myself and including those that are involved in private equity do release voluntary quality reports that report on our indicators, many of which are the same as the Advancing Excellence campaign. The American Health Care Association supports transparency but I urge the Committee to be careful that we don't restrict capital in our profession, in our industry. We are serving our patients and our residents in outdated buildings, many of which were built in the 1960s and 1970s. If we disclose all relationships, we may discourage banks which lend our corporation money and have really no say-so in our operations from investing in our industry.

Mr. STUPAK. I think what we are trying to say is, we need to know who do you go to, and not have to discover which shell the pea is under. You know, if your number of entities limited liability corporations, fine. Someone is in charge of making decisions about that facility; who is it. That is who we need to know so the ombudsmen can do their job without having to go to litigation. Mr. Kramer?

Dr. KRAMER. I would just like to say that I concur with the notion of transparency and that there ought to be much more information available to residents and to discharge planners and people making these decisions. One of the things I think we need to keep working on is the breadth of that information, and again, I come back to QIS because of the breadth. It covers quality-of-life issues and a full range of the regulatory areas. It turns out that a lot of times the issues that are most important to residents are things like self-determination, somebody waking you up at 5 in the morning versus getting up, things that Dr. Koren talked about. That information is not very available, and there are some very important things that we need to make available and I think we can do that with a much broader array of information than we currently provide people.

Mr. STUPAK. We ask for transparency from the ownership and from the nursing homes but we still need transparency from CMS on the Kramer report and the QIS report, and we are still waiting on that.

Dr. KRAMER. I mistakenly did not comment about the QIS evaluation report and I should just tell you something about it since I do know about it. One of the reasons it hasn't been released is that it is inconclusive. It took a long time to do. They actually only went on 10 QIS surveys, and in their own words, they qualify these findings by noting, "the comparisons between QIS and standard surveys were limited by sample size, thus the data we provide are best used for survey improvement purposes rather than to inform decisions about what type of process." So they ended up with a very modest study that wasn't actually conclusive and didn't really address the consistency issue. So I know there is a lot that needs to be done to put that in context and say how CMS is going to address the concerns here but move forward. And they all recommended to move forward with QIS and so that is why CMS has moved forward.

Mr. STUPAK. Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman. I don't really have a lot more but I do want to follow up. You may not have the answer, but it is my understanding that hospitals provide more information. The irony behind this is that hospitals have to provide more information. Then you have the discharge planner who is not really requiring or helping in sending someone to a facility. We all know the recidivism aspect. I don't know if that is the right word. But if you go to a place where the care is not great, you could be bounced back to the hospital. So the whole aspect of—you would hope, if you are concerned about the patients and the wellness that the discharge planner would want to encourage care to a proper provider. Maybe there is concerns about—I don't know. Why wouldn't they—Dr. Zimmerman, it looks like you want to respond.

Dr. ZIMMERMAN. Well, I am not sure why they would not want to know. I think that there hasn't been a really organized way of providing the information, et cetera, but frankly, the transition of care between settings is, to put it bluntly, one of the scariest aspects of our care problem now with the elderly. It is abysmally bad in terms of the transfer of information from the acute care setting to just about any other setting, whether it is home care, whether it is skilled nursing facilities, whether it is a hospice, whether it is a long-term acute care hospital, et cetera. In my testimony, I said the following, which I can repeat very quickly if you will permit me. If we are truly to accomplish the goal of giving our elderly citizens the care they so richly deserve, then we need to expand our focus to include the other care provider settings that feed into skilled nursing facilities. In particular, this must include greater scrutiny of acute care hospitals whose discharge practices have placed enormous pressures on skilled nursing facilities because sometimes they will discharge folks before they are ready to be discharged and sometimes the hospital itself is inadequately prepared to provide the complex care needed by elderly patients. We have some hospitals that have a program called an ACE program, Acute Care for the Elderly. About 40 hospitals around the country have this program. But often they don't, and frankly, that is not their business. That is not, as we say in economics, their comparative advantage. And so I think we have to be very careful to make sure that this setting transfer is handled more carefully than it is now.

Mr. SHIMKUS. I appreciate those comments. It is kind of scary and it is scary for families too as they are trying to move people through the process. In some hospitals in southern Illinois, because of the way just regular healthcare has changed from inpatient to outpatient, they have beds and they have segued into skilled nursing facilities. So I imagine in that facility where you have limited choices, I would think and I will go check with my local providers, that is not a big a problem because you are just going from really one wing of the hospital to another. But I just want to—I will make a comment on the—I would think if I was a provider and I had my own quality assurance program or the Advancing Excellence issue, that is something I would be advertising and throwing information out, as Dr. Zimmerman said. I mean, it is an aspect of where you can get a competitive advantage as people are looking for quality care.

This whole resident-centered care, which we all know is—we all want to be individuals. We want individuals in education planning. We don't want to be segmented into groups. That has got to cost a little more, doesn't it?

Dr. KOREN. What we are finding, at least what we found from the survey that we just conducted, was that in fact there seems to be a positive effect on the bottom line. It might be a program that costs before it saves, but ultimately as you start to empower staff, as you start to make them in charge of their own residents and make it a better job, you have lower turnover, you have happier residents, you have higher occupancy rates, you have fewer lawsuits, you are not being dinged on surveys. I mean, there are huge advantages to really individualizing the care and taking care of those people, and it is really trying to get people to understand that, that not only is it a good way to do business but it is the right way to do business.

Dr. KRAMER. And I would concur with her. You know, the problem is not a cost issue to start doing resident-centered and culture change care. The issue has more to do with the focus of our whole regulatory system and our whole quality-of-care system. Quality of life has not been part of that focus for a long time, and the amount of reliance on what residents and families tell surveyors has not really been the focus. And it is starting to become the focus and it needs to be the focus of the regulatory process and the quality improvement process.

Mr. PRUITT. I would say as a provider, there are aspects of resident-centered care which absolutely do not cost more. It is instead a way of changing how you operate a building. For instance, traditionally, nursing homes in many of our state regulations require higher staffing on the first shift. Well, many of our patients don't wish to be bathed or have their activities of daily living performed on the first shift. They may have done that traditionally at night. So as an operator, as we have more consistent staffing across all shifts, it is a reallocation of resources and it becomes more outcome driven, more customer satisfaction driven than necessarily regulatory driven.

Mr. SHIMKUS. I thank you very much.

Mr. Chairman, since I have no more questions for this panel, I don't want to segue into the high cost of energy for healthcare delivery. That is a debate for another time.

Mr. STUPAK. I am always willing to have that debate with you.

Residents at Pine Crest Medical Care Facility, which you probably know in the Powers area, has opened a couple of these residences and I was there 2 weeks ago as they cut the ribbon and all this, and it was really interesting that these were probably some of the most severely injured people but they were so excited and they did one a year earlier so this would be their second one, and I asked about the cost and the initial cost to build the building with special features. There is a cost there, but in the long run, happier, staff is happier and the quality of life that you speak of was much greater. So I think there are a lot of good things happening.

Let me ask you one question if I can. How often does a hospital person call and say we are discharging such and such who just had major surgery, can you handle them or what would you recommend? Do you have that much interaction with a hospital on a discharge or is it just the family heard about you and showed up with their loved one?

Mr. PRUITT. We have tremendous interaction with the acute care setting. The discharge planners in the hospital routinely contact nursing facilities to understand their capabilities of caring for patients. They will then find several options for the family. They will inform the family of their choices. We know from our satisfaction surveys that we conduct that our family members visit several facilities before ultimately deciding on ours so from our corporation standpoint, and I believe I can say from the industry as a whole, there is tremendous interaction with acute care settings.

Mr. STUPAK. Let me thank this panel. It has been most interesting, and thank you very much for your input into this problem that it has been 31 years since this subcommittee has visited it. We will keep on it, I can guarantee you. I think we all have some personal experiences we can relate to and we appreciate what you do and helping us understand it. Thank you.

As I call up our witness on the third panel, we have Mr. Kerry Weems, who is the acting administrator at the Centers for Medicare and Medicaid Services, CMS, as we call it, within the Department of Health and Human Services, and we appreciate the fact that you stayed with us all day today and have been interacting as we had a chance to say hello out in the hall. It is the policy of this subcommittee to take all testimony under oath. Please be advised that witnesses have the right under the Rules of the House to be advised by counsel during their testimony. Do you wish to be advised by counsel during your testimony, Mr. Weems?

Mr. WEEMS. No, sir.

Mr. STUPAK. OK. Then I will ask you to please rise, raise your right hand and take the oath.

[Witness sworn.]

Mr. STUPAK. Thank you, sir. Let the record reflect that the witness replied in the affirmative. He is now under oath. We will begin with your opening statement, and again, 5-minute opening statement. A lengthier statement can be submitted for the record.

Mr. Weems.

STATEMENT OF KERRY WEEMS, ACTING ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. WEEMS. Thank you very much, Mr. Chairman. Good afternoon. Mr. Shimkus, good afternoon. Congratulations on your decision to retire, which I guess we——

Mr. SHIMKUS. Yes, from the Army Reserves. My wife called and said no, you are not leaving.

Mr. WEEMS. Congratulations on your service there.

Thank you for inviting me to testify today. Roughly 1½ million Americans reside in the Nation's 16,000 nursing homes on any given day. More than 3 million rely on the services provided by a nursing home at some point during the year. Those individuals, their families and friends must be able to count on nursing homes to provide reliable care of consistently high quality.

Charged with overseeing the Medicare and Medicaid programs, whose enrolled populations comprise the vast majority of home residents, CMS takes nursing home quality very seriously. Our efforts are broad including initiatives to enhance consumer awareness, transparency, as well as vigorous survey enforcement processes focused on safety and quality.

Consistent with statutory requirements, we conduct onsite reviews of every nursing home in the country at least once every 15 months, once a year on average. Surveys focus on the quality of care experienced by facility residents regardless of who owns the facilities. Our focus on actual outcomes ensures that Medicare's quality assurance system does not depend on particular ownership of a facility. We do continuously seek to improve the effectiveness of both the survey process and the enforcement of quality care requirements. An example of such continuous improvement is our Special Focus Facilities initiative, which addresses the issue of nursing homes that persist in providing poor quality. This relatively new initiative is just one of many efforts underway at CMS to further improve nursing home quality.

I have brought a chart with me today that includes a set of commitments I made last November before a Senate panel, and it has been updated to show progress to date. Beginning with the green checks, those represent actions completed. CMS participation in leadership and Advancing Excellence in Nursing Homes campaign continues. On November 29, 2007, we posed on our Web site the Nursing Home Compare, the names of the Special Focus Facilities, a major step forward in greater transparency toward nursing home quality. We expanded the Quality Indicator Survey pilot in February to include a sixth State, and we are looking forward to more promising results. Last month CMS cosponsored a well-attended national symposium on nursing home culture change.

Now, moving to the work in front of us, which represents actions in progress, I believe we are nearly ready to be able to roll out a demonstration project focusing on value-based purchasing for nursing homes, which would test payment incentives to improve quality. We are also working on a final evaluation of a 3-year pilot to test a system of criminal and other background checks for perspec-

tive new hires in nursing homes. Target release of this final report is this summer. In June, we expect to publish results from an ongoing campaign to reduce the incidence of pressure ulcers in nursing homes and to reduce the use of restraints. In July we hope to publish new guidance to surveyors on nutrition in nursing homes, the latest of an ongoing CMS effort to improve the consistency and effectiveness of the survey process.

In August, our new contract with the quality improvement organizations will take effect. We plan to build into that contract an ambitious, unprecedented 3-year agenda for QIOs to work on nursing homes that have poor quality including those in the Special Focus Facilities. Also in August, we plan to release a final regulation on fire protection safety requiring all nursing homes to be fully sprinkled by a phase-in period.

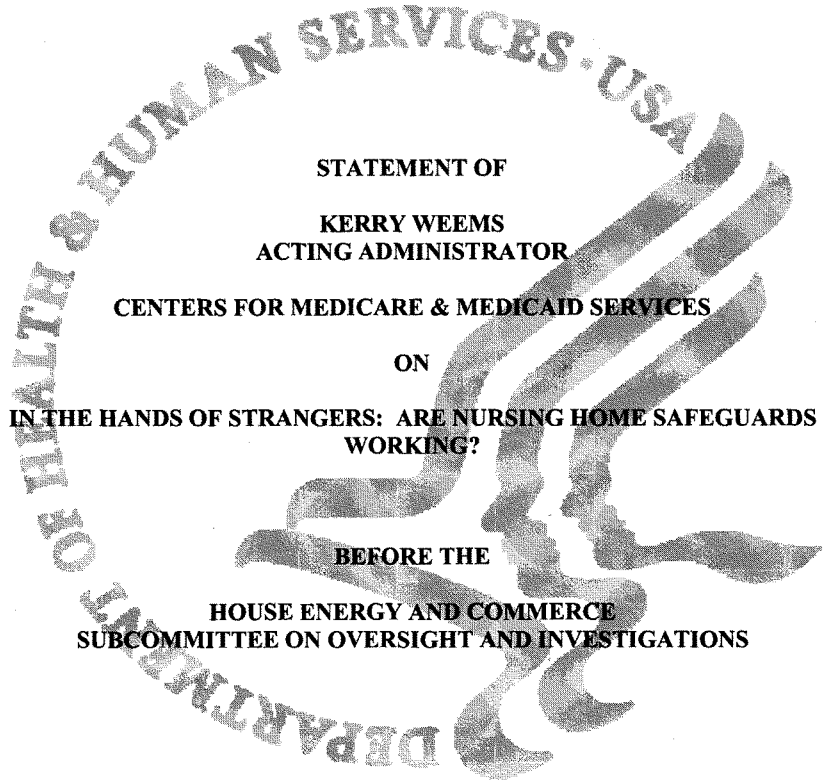
In September we hope to issue a report describing the methods for improving the accuracy of staffing information available for posting on the Nursing Home Compare site.

Finally, as I have stated previously, we would envision supporting legislation to permit the collection and escrow deposit of civil monetary penalties as soon as the penalties are imposed.

In closing, I would like to again stress that regardless of setting or ownership, quality health and long-term care for Medicare and Medicaid beneficiaries is of utmost importance to CMS.

I would be happy to answer your questions. Thank you for the opportunity to appear today.

[The prepared statement of Mr. Weems follows:]



STATEMENT OF

KERRY WEEMS
ACTING ADMINISTRATOR

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

IN THE HANDS OF STRANGERS: ARE NURSING HOME SAFEGUARDS WORKING?

BEFORE THE

HOUSE ENERGY AND COMMERCE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

May 15, 2008

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Testimony of
Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

Before the
House Energy and Commerce
Subcommittee on Oversight and Investigations
On
In the Hands of Strangers: Are Nursing Home Safeguards Working?

Good afternoon Chairman Stupak, Representative Shimkus and distinguished members of Congress. It is my pleasure to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS) initiatives undertaken in the past few years to improve the quality of care for nursing home residents. Our quality efforts in this area are broad, including initiatives to enhance consumer awareness and transparency, as well as rigorous survey and enforcement processes to ensure nursing facilities provide quality care to their residents.

Background

Americans are growing older and living longer – many with complex, chronic medical conditions. As increasing numbers of our nation's baby boom generation retire, the need for high-quality long-term care, both in the community and in nursing homes will grow commensurately. About 1.5 million Americans reside in the nation's 16,000 nursing homes on any given day.[1] More than 3 million Americans rely on services provided by a nursing home at some point during the year.[2] Those individuals, and an even larger number of their family members, friends, and relatives, must be able to count on nursing homes to provide reliable care of consistently high quality.

[1] Centers for Medicare & Medicaid Services. *2008 Action Plan for (Further Improvement of) Nursing Home Quality* (http://www.cms.hhs.gov/CertificationandCompliance/Downloads/2008NHActionPlan.pdf).
[2] *Ibid.*

In 2006, 7.4 percent (2.8 million) of the 37.3 million persons aged 65 and over in the United States stayed at a nursing home.[3] By contrast, 22 percent of the 5.3 million persons aged 85 and older stayed at a nursing home in 2006. Some of these were long-term nursing home residents, while some had shorter stays for skilled nursing care following an acute hospitalization.[4]

Roughly 1.8 million persons received Medicare-covered care in skilled nursing facilities in 2005.[5] Medicare skilled nursing facility benefit payments increased from $17.6 billion in 2005 to nearly $21.0 billion in Fiscal Year (FY) 2007.[6] Approximately 1.7 million persons received Medicaid-covered care in nursing facilities during 2004.[7] Medical assistance payments for Medicaid-covered nursing facility services topped $47 billion in FY 2005, representing nearly 16 percent of overall medical assistance payments that year.[8]

Action Plan for Nursing Home Quality

Congress has authorized a variety of tools that enable CMS to promote – in the words of the statute – "...the highest practicable physical, mental, and psychosocial well-being of each resident..."[9] The most effective approach to ensure quality is one that mobilizes all available tools and aligns them in a comprehensive strategy. An internal CMS Long Term Care Task Force helps shape and guide the Agency's comprehensive strategy for nursing home quality. Each year, CMS publishes a comprehensive *Nursing Home Action Plan*[10] on our web site, which reflects the vision and priorities of the Task Force and the Agency. The current *Action Plan* outlines five inter-related and coordinated approaches – or principles of action – for nursing home quality, as described in detail below.

---

[3] Centers for Medicare & Medicaid Services. *Nursing Home Data Compendium* (http://www.cms.hhs.gov/CertificationandComplianc/12_NHs.asp#TopOfPage).
[4] *Ibid.*
[5] U.S. Department of Health and Human Services. *2007 CMS Statistics* at 4 and 34. Washington D.C.: U.S. Government Printing Office.
[6] *2007 CMS Statistics* at 3 and 28.
[7] *2007 CMS Statistics* at 4 and 39. "Nursing facility" in this context includes SNFs and all other nursing facilities other than intermediate care facilities (ICF/MR).
[8] *2007 CMS Statistics* at 29. Note these figures exclude payments under SCHIP.
[9] Section 1819(b)(2) of the Social Security Act.
[10] See http://www.cms.hhs.gov/CertificationandComplianc/12_NHs.asp#TopOfPage

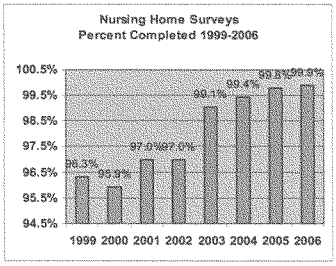
Consumer Awareness and Assistance. The first principle of action is consumer awareness and assistance. Aged individuals, people who have a disability, their families, friends, and neighbors are all essential participants in achieving high quality care in any health care system. The availability of relevant, timely information can significantly help such individuals to be active, informed participants in their care. This information also can increase the ability of such individuals to hold the health care system accountable for the quality of services and support that should be provided. To that end, CMS seeks to provide an increasing array of understandable information that can be readily accessed by the public.

With regard to nursing home care specifically, the CMS web site "Nursing Home Compare" at www.Medicare.gov features key information on each nursing home; the results of their three most recent quality of care inspections; and other important information for consumers, families, and friends. The web site contains the results of 19 different quality of care measures for each nursing home, such as the percent of residents who have pressure ulcers or are subject to physical restraints. Recently, CMS added information about the extent of fire-safety features in each nursing home and any deficiencies. CMS also added information about the percent of residents who were vaccinated for flu and pneumonia.

Survey, Standards, and Enforcement Processes. The second principle is to have clear expectations for quality of care that are properly enforced. CMS establishes both quality of care and safety requirements for providers and suppliers that participate in the Medicare and Medicaid programs. Such requirements are carefully crafted to highlight key areas of quality and convey basic, enforceable expectations that nursing homes must meet. Consistent with statutory requirements, more than 4,000 Federal and State surveyors conduct on-site reviews of every nursing home at least once every 15 months (and about once a year on average). CMS also contracts with quality improvement organizations (QIOs) to assist nursing homes to make vital improvements in an increasingly large number of priority areas. In August of this year, a new CMS contract

for the QIOs will take effect. CMS plans to build into that contract an ambitious, 3-year agenda for the QIOs to work with nursing homes that have poor quality, including the Special Focus Facilities (SFFs).

We take our responsibilities for on-site surveys of nursing homes seriously. In 2006, the most recent year for which complete data are available, the percent of nursing homes that were surveyed at least every fifteen months reached 99.9 percent – the highest rate ever recorded. In addition to about 16,000 comprehensive surveys that year, CMS and States conducted more than 45,000 complaint investigations in nursing homes. Our strengthened fire-safety inspections led to the identification of 67.8 percent more fire-safety deficiencies in 2006 compared to 2002 (to 66,470 from 39,618). Nursing homes have responded to these findings by improving their fire-safety capability.



Quality Improvement: The third *Nursing Home Action Plan* principle is to have effective quality improvement strategies. CMS is promoting a program of quality improvement in a number of key areas. These areas include reduction in the extent to which restraints are used in nursing homes; reduction in the prevalence of preventable pressure sores that threaten the health and well-being of a significant number of nursing home residents; and the Agency's participation in a larger national movement known as "culture change." Culture change principles echo Omnibus Budget Reconciliation Act (OBRA) of 1987 principles of knowing and respecting each nursing home resident in order to provide individualized care that best enhances each person's quality of life. The concept of culture change encourages facilities to change outdated practices to allow residents more input into their own care and encourages staff to serve as a team that responds to what each person wants and needs. This past April, CMS co-sponsored a well-attended national symposium on culture change and we anticipate the recommendations that came out of the symposium will be available in the near future.

Quality Through Partnerships: The fourth *Nursing Home Action Plan* principle is to promote quality through enthusiastic partnerships with any and all organizations that will join with us. No single approach or actor can fully assure quality. CMS must mobilize and coordinate many actors and many techniques through a partnership approach. State survey agencies and the QIOs under contract with CMS are more than ever coordinating their distinct roles so as to achieve better results than could be achieved by any one actor alone. CMS is also a founding member of the "Advancing Excellence in America's Nursing Homes" campaign. This campaign is a collaboration among government agencies, advocacy organizations, nursing home associations, foundations, and many others to improve the quality of nursing homes across the country.[11] The campaign voluntarily enlists nursing homes to measure and make improvements in eight key quality of care areas. More than 6,000 nursing homes have signed up to make quality improvements such as the consistent assignment of staff to individual nursing home residents; the assessment of satisfaction on the part of residents and families; or the reduction of pressure ulcers.

Value-Based Purchasing: The fifth principle of the *Nursing Home Action Plan* is to use purchasing power to promote quality. As the largest third-party purchasers of nursing home services in the country, States and CMS exert leverage to insist on certain levels of quality. CMS is working collaboratively with private and public organizations to stimulate high quality care and improve efficiency. Payment reforms could show promise in encouraging providers to deliver care that prevents complications, avoids unnecessary medical services, and achieves better outcomes at a lower overall cost.

With these five principles in mind, the testimony will now turn to two topics that we understand may be of special interest to the Committee. The first is the issue of nursing home ownership, and the second is the CMS "Special Focus Facility" initiative.

---

[11] Information about the campaign for *Advancing Excellence in America's Nursing Homes* may be found at: http://www.nhqualitycampaign.org

Nursing Home Ownership

CMS is aware of recent media reports about the relationship between quality nursing home care and nursing home ownership, particularly investor-owned facilities. We understand the importance of responsible ownership of nursing facilities serving the Medicare and Medicaid population.

CMS has developed a system called the Provider Enrollment Chain and Ownership System (PECOS). This electronic system is designed to capture and maintain enrollment information submitted via the provider enrollment application, including information regarding entities that own five percent or more of a nursing home and to ensure only eligible providers and suppliers are enrolled and maintain enrollment in the Medicare program. Beyond the five percent ownership interest requirement, the PECOS system also reflects any entity that has managing control of the provider or partnership interest in the provider, regardless of the percentage of ownership the partner has.

The primary function of the provider enrollment application is to gather information from a provider or supplier that tells CMS who it is; whether it meets State licensing qualifications and federal quality of care and safety requirements to participate in Medicare; where it practices or renders its services; the identity of the owner of the enrolling entity; and information necessary to establish the correct claim payment. The PECOS database currently has enrollment information on 70 percent of nursing homes enrolled in the Medicare program. Nursing homes are required to submit updates to their existing provider enrollment when they have a change in information, such as ownership, which then populates the PECOS database. Using PECOS, CMS has the ability to better track ownership and changes in ownership. CMS also is developing an Internet-based enrollment application which will allow all providers, including nursing homes, physicians and other suppliers to enroll or update their enrollment information via the Internet. We believe that the new approach will allow nursing homes to maintain up-to-date enrollment information.

CMS focuses on the quality of care experienced by residents regardless of who owns the facility. Our focus on actual outcomes ensures that Medicare's quality assurance system does not depend on any theory of quality or theory of ownership. Instead, the federal survey and certification system is grounded in what CMS and State nursing home surveyors actually find through on-site inspection; through in-person interviews with residents and staff; through the eyewitness observation of care processes; and through the review of records of care.

CMS continuously seeks to improve the effectiveness of both the survey process and the enforcement of quality of care requirements. An example of such continuous improvement is our Special Focus Facility initiative that addresses the issue of nursing homes that persist in providing poor quality.

Special Focus Facility Program

The Special Focus Facility (SFF) program was initiated because a number of facilities consistently provided poor quality care, yet periodically fixed a sufficient number of the presenting problems to enable them to pass one survey, only to fail the next survey. Moreover, they often failed the next survey for many of the same problems as before. Such facilities with an "in and out" or "yo-yo" compliance history rarely addressed the underlying systemic problems that were giving rise to repeated cycles of serious deficiencies.

Nursing homes on the Special Focus list represent those with the worst survey findings in the country, based on the most recent three years of survey history. The selection methodology takes into account the severity of deficiencies and the number of deficiencies. Deficiencies identified during complaint investigations are also included in the computation. Each State selects its Special Focus nursing homes from a CMS candidate list of approximately 15 eligible nursing homes in their own State, using additional information available to the State regarding the nursing homes' quality of care in order to make the final selection. As of April 2008, there were 134 SFF-designated homes, out of about 16,000 active Medicare- or Medicaid-participating facilities. As

homes improve their quality of care and "graduate" from the program, or fail to improve and are terminated from Medicare and Medicaid, new homes are added to the list.

States conduct twice the number of standard surveys for Special Focus nursing homes compared to other nursing homes. If serious problems continue, then CMS applies progressive enforcement until the nursing home either (a) graduates from the Special Focus program because it makes significant improvements that last; (b) is terminated from participation in the Medicare and Medicaid programs; or (c) is given more time due to a trendline of improvement and promising developments, such as sale of the nursing home to a new owner with a better track record of providing quality care.

To analyze the impact of the Special Focus Facility initiative, CMS compared the 128 nursing homes selected in 2005 with alternate nursing homes on the candidate list that were not selected. The Special Focus nursing homes had more deficiencies than others: 11 deficiencies on average in the Special Focus Facilities compared with 9 deficiencies for the alternates and 7 for nursing homes on average. However, over the course of the next two years approximately 42 percent of the Special Focus nursing homes had significantly improved to the point of meeting the Special Focus Facility graduation criteria, whereas only 29 percent of the alternates had equally improved. At the same time, change of ownership or closure of poorly performing nursing homes was greater in the Special Focus nursing homes. Approximately 15 percent of the Special Focus nursing homes were terminated from participation in Medicare compared with less than 8 percent in the alternates and 2 percent for all other nursing homes. The better response of the Special Focus nursing homes in addressing deficiencies has been a function of the greater attention that CMS paid to those nursing homes on the Special Focus Facility list, and the imperative for action that is built into the Special Focus Facility program design.

The Special Focus initiative can pay great quality-of-care dividends for nursing home residents. For example, a nursing home in rural Monck's Corner, South Carolina, was a Special Focus nursing home that failed to improve significantly over the 18 months after it was first selected. As a result, in April 2007 CMS issued a Medicare notice of

termination to the facility. We were prepared to see the 132 nursing home residents relocated to other facilities that provided better care. At that point, however, the nursing home operators evidenced a willingness to implement the type of serious reforms that had clear potential to transform their quality of care. CMS agreed to extend the termination date provided the nursing home would enter into a legally-binding agreement to institute certain quality-focused reforms. We required that they undergo a root cause analysis of their underlying systems-of-care deficiencies, to be conducted by a QIO selected by CMS. We required that the nursing home then develop an action plan based on the root cause analysis, and also place $850,000 in escrow to pay for the reforms indicated by the action plan and root cause analysis. These interventions were successful. The nursing home passed the subsequent survey, was purchased by another owner, and is on track to graduate later this year from the Special Focus Facility initiative provided it can sustain the improvements over time. The corporation that operated the nursing home is now seeking to replicate this approach with other nursing homes that it operates.

For the past several months, CMS has been working to bring added transparency to the SFF program. Increased consumer transparency on the initiative started in November 2007, when CMS began publishing on www.medicare.gov the list of SFF-designated nursing homes on the www.medicare.gov web site. In February 2008 we published an updated, expanded list of nursing homes in the SFF initiative, including further information on their specific designation (*e.g.*, new addition, not improved, improving, recently graduated or no longer in the Medicare and Medicaid programs). Last month, we linked the posted SFF information to the Nursing Home Compare web site, with nursing home SFF designations now noted on Nursing Home Compare. We will continue to evaluate the impact and potentially build upon these efforts to promote increased consumer transparency.

Conclusion

Mr. Chairman, thank you for the opportunity to testify here today. Regardless of setting or ownership, quality health and long-term care for Medicare and Medicaid beneficiaries is of the utmost importance to CMS. To that end, I plan to work to ensure high quality

medical care for all nursing home residents. I would be pleased to address any questions or hear any comments you may have.

Mr. STUPAK. Well, thank you, and thank you again for being with us.

Let me ask you, and I sort of ended the last panel with it, and I think you heard Attorney General Blumenthal's call for a national database to which State officials would have access showing problem nursing home chains and facilities. What is wrong with that idea? Doesn't CMS have an obligation to protect those vulnerable patients in these homes? And why can't CMS take the lead on sharing that type of information that would be readily available to everybody?

Mr. WEEMS. Much of that information is available now so, for instance, if you go to the Nursing Home Compare Web site, the last three surveys taken are available—a summary of the last three surveys taken are available on the nursing home——

Mr. STUPAK. So for every nursing home, that is available? Is that what you are saying?

Mr. WEEMS. For every nursing home, the last three—a summary of the last three surveys are available on the Web site.

Mr. STUPAK. So what are there, 7,000 nursing homes or so?

Mr. WEEMS. Sixteen thousand, four hundred.

Mr. STUPAK. Sixteen thousand. I am sorry. So you have 45, almost 52,000 summaries out there?

Mr. WEEMS. Yes.

Mr. STUPAK. Then why in the PECOS system—that is your Provider Enrollment and Chain Ownership System, currently only has 70 percent of the nursing home ownership information database? Even if the Medicare provider discloses everything requested on your enrollment forms, in PECOS, we are still missing 30 percent as to ownership and other identifiable features that would help people to know more about that nursing home.

Mr. WEEMS. And that is a good question. First of all, I think the thing that we need to understand, the CMS PECOS initiative isn't just for nursing homes. It is for all providers and so we enroll them at—all providers except one particular type. We enroll them at a particular pace. That pace is about 250,000 to 300,000 a year and so the 70 percent figure represents the progress that we have made enrolling a very, very large number of providers into the system.

Mr. STUPAK. Well, they tell me that the ownership issue, and I am focusing a little bit on that because that is what we have sort of been talking about on the first panel, is really not linked to the CMS Web site, to the Nursing Home Compare Web site.

Mr. WEEMS. Right.

Mr. STUPAK. So you almost have to go two different places to even try to find it.

Mr. WEEMS. Yes, and one of the things that we focused on for Nursing Home Compare are indicators that we believe that would be useful in selecting a nursing home, so some of the quality indicators, things like that. We are collecting the ownership information as a matter of—as a data field in PECOS and in fact we will collect it down to fractional ownership of 5 percent. I think the question that we all confront is, how meaningful is that information in selecting a nursing home, to put it on Nursing Home Compare? It may have other meaning.

Mr. STUPAK. Right, but it wasn't just for a private family to select a nursing home. It is also for the ombudsmen, so when you have these corporate layers of corporate responsibility, who does he go to? The facility manager wants to do the right thing but they don't have the power so who do you go to, and even the attorney general indicated he had trouble. And I think Mr. Walden said in this modern era, data is available it seems like sort of piecemeal here. We need a central location. We sort of need to link the ownership database to a quality database into one database so if we are looking for quality, if we are looking for the family, if you are looking for who is in charge to put a little pressure to clean up a matter at a facility or the state attorney general has to do something like Connecticut had to do, there is one place we can go.

Mr. WEEMS. Let me begin by agreeing with that but then let us step back and think about how we make that information useful. Is our goal to populate PECOS 100 percent? Having done that, it is also our goal then to link that to the quality data that we have. Let me tell you that yes, we do have that as a goal. That will have some use. Let us separate that use, however, from what is on Nursing Home Compare. Nursing Home Compare, we want to make sure that we have information that is usable in selecting a nursing home. So I am not sure that integrating those two databases achieves the kind of objective that you have in mind. I think we have different purposes for different databases.

Mr. STUPAK. Well, I guess that is the only place we can go to really look to see where the bad actors in this field are. I think the testimony has shown on the other panels, it is a small number, but unfortunately, a small number when they do are bad actors, it hurts, has tragic results. Let me ask you this. CMS Special Focus Facilities program appears to be a promising way to deal with nursing homes that have a record of actually harming or jeopardizing patients. GAO has repeatedly reported that about 20 percent of nursing homes have serious problems and cycle in and out of compliance, and with the figure you had, over 16,000 before, that would be about 3,200 facilities nationwide moving in and out of compliance yet only a couple hundred of facilities are in the SFF program. Why wouldn't that program be expanded to try to get at this total 20 percent?

Mr. WEEMS. We would like to expand the program. The program right now has about 134, 135 facilities in it. It is a program that is resource-intensive. It requires surveying at twice the normal rate. Within the resources that we have, it is something that we would look to expand.

Mr. STUPAK. Let me ask this since I asked Dr. Kramer and I would like to have your response on it. Dr. Kramer's group at the University of Colorado, the report commonly referred to as the Kramer report, which was completed March of last year, 2007, and it was approved by the project officer, so why hasn't CMS released that report?

Mr. WEEMS. You heard Dr. Kramer say that it wasn't a particular conclusive report.

Mr. STUPAK. I thought that was the Quality Indicator Survey, the QIS.

Mr. WEEMS. You are right.

Mr. STUPAK. The Kramer report has been done for a long time.

Mr. WEEMS. Right. Both of those reports we have. We are reviewing. One of the things we like to do when we have a report and when we release it is to have an action plan associated with it. I would like to have both of those reports out and available this summer. Rather than just releasing a report, let us have an action plan. Let us see what we are going to do about it.

Mr. STUPAK. Well, I don't disagree necessarily with that but does it take 15 months to develop an action plan? That is how long the Kramer report has been done. QIS, I understand, that has been 5 months but I don't think it would take 15, 16 months, 17 months to put forth an action plan.

Mr. WEEMS. It takes a while to go through a report, review it and produce those things.

Mr. STUPAK. Let me ask you this. The nursing home industry presented a strong case here, and I would get from their testimony, I would take away that voluntary quality initiatives can take the place of regulation. At least that is what I heard them say. But information about whether a chain or a facility has achieved voluntary benchmarks is not public unless the company chooses to make the information public. Do you believe that this type of system can or should replace the current regulatory system or QIS system?

Mr. WEEMS. I think it is something that is worth looking at in a very serious way. I think going through the research, being able to see if in fact it makes a difference, and I think it is important to separate the regulatory system from the enforcement system. I would be loathe to suggest that we need to loosen up the enforcement system. Perhaps we can take another look at the regulatory system. We are doing that, seeing the cultural change, more person-centric care that we are looking at. That can make a difference. We need to proceed carefully down that path, maybe lift off some of the regulations, keep the enforcement regimen in place.

Mr. STUPAK. Thank you.

Mr. Shimkus.

Mr. SHIMKUS. Thank you for your testimony, and you kind of really highlighted the challenge that a lot of us are trying to get our hands around, which is the regulatory or enforcement, and we keep bringing it up. There is a State responsibility here too. There is licensing and there is what they have to do to be involved with it. In my opening statement, I quoted the fact that we have been successful to some extent in unfortunately recovering millions of dollars in penalties for noncompliance. Our hook in this debate is because we are big payers. Isn't that right?

Mr. WEEMS. Correct.

Mr. SHIMKUS. And we are big payers because of the Medicare and the Medicaid.

Mr. WEEMS. Yes.

Mr. SHIMKUS. So a lot of this debate is trying to follow, you know, the money to the ultimate ownership for quality care and really, is finding out the ownership—I can see how it is beneficial but is it the end-all to improving quality care?

Mr. WEEMS. Let me tell you how we think about and our thinking about ownership now. Currently CMS's relationship is with the

owner of the provider agreement so whoever has that provider agreement is the entity with which we have the relationship. So what would chain ownership or some other ownership tell us? Looking, for instance, at the case the Committee had in front of it this morning, so if you see a couple of homes in a chain beginning to fail, what does that tell you? And that is the thing we need to work on. So it is 2 of 20 then that would require an intervention or is that just statistical chance as opposed to a corporate strategy? Is it four, is it six? Those are the kinds of things that we need to investigate with understanding ownership, distinguishing the difference between does it matter or how it matters and when to intervene.

Mr. SHIMKUS. Kind of following up on the same question, in your testimony on page 8, you say that Medicare's quality assurance system does not depend on any theory of ownership.

Mr. WEEMS. That is correct. Our relationship is with the facility itself and the holder of the provider agreement in that facility so——

Mr. SHIMKUS. You are saying because of this holder of the provider agreement, but I guess part of the debate is, the holder of the provider agreement may not be the final owner. And so that is the disconnect that we are trying to clear up.

I think, Mr. Chairman, I am kind of out of questions, so I will yield back to you for a while.

Mr. STUPAK. Well, fine, jump in if you want.

Let me just follow up, just talking about ownership there. Doesn't it follow then that irresponsible nursing home owners can have a negative effect on the quality of their facilities? If we take a look at what happened at the quality of care at the Haven Health Care chain, didn't it make a difference who owned the chain for the quality of care? Why should owners be allowed to hide behind a complex web of limited liability partnerships and not knowing who they are?

Mr. WEEMS. And they shouldn't. That is why our system will capture ownership down to the fractional level of 5 percent.

Mr. STUPAK. But see, that is why I want the data at one place whether it is police, attorney generals or whatever, enforcement, regulators, they got one place to go along with the family so you can see what is happening at all aspects of it.

You know, when you said chain ownership, that they have two or three or four facilities going bad, where do you draw the line? Where do you step in? Is it really the number of facilities? Isn't it more the seriousness of the deficiency which would say when you step in?

Mr. WEEMS. It would be both. I would say that we don't have the research now to be able to separate, as we would say, the signal from the noise, and it is a very serious question and one that we should look at because there are varieties of chains, varieties of types of ownership, and varieties of numbers of facilities in a chain and varieties of size in a chain. Each one of those could be a variable in what could be a very complex equation. We want to proceed but we are just not in a position now to be able to say, is it 2 in 100 of this particular type of what.

Mr. STUPAK. OK. I will give you that as far as the ownership issue but where we should be going, the value of these surveys, the information gleaned there from, I think has sort of fallen on deaf ears at the CMS. Nineteen ninety-eight was the last time GAO did a study and they just released another one today, and I know you probably didn't have time to take a look at it.

Mr. WEEMS. We commented on it.

Mr. STUPAK. Yes, but if you take what happened in 1998 and you go back to look what happened today, today's report from the GAO really shows there are very serious problems with the current nursing home survey system so we are not getting at the deficiencies. I realize, like you said, you might not have had a chance to read it all but they are similar to those of the University of Colorado study which you have had for about 17 months and haven't released and to the OIG, Mr. Morris, who testified, and again the 1998. So I look at the 1998, I look at the one today. I had a chance to read it between votes, take a look at a couple things. It is almost the same. You put that with the Kramer report, as I call it, or the Kramer study from Dr. Kramer of the University of Colorado, OIG, and it seems like we are seeing the same thing: very serious problems with the current system of nursing home survey system so today that survey has failed to identify serious deficiency 25 percent or more of the time. Even more troubling, in all but five States, surveyors missed deficiencies at the lowest level of compliance, and the lowest level of compliance, undetected care problems at this level are a concern because they could become more serious if nursing homes are not required to take corrective action. So how will CMS remedy this situation?

Mr. WEEMS. Stepping back from that, first of all, one of the first things that we would like to happen is, let us make sure the survey gets done so that if you look at the record of CMS from 2000 to today, 2000, 4 percent of surveys weren't being done. We are down to about four-tenths of 1 percent aren't being done. So as a first step, at least the surveys themselves are being done.

Mr. STUPAK. Sure, but surveys have to have quality. They have to be quality surveys. I can go and give you every survey you want and I can follow up on the phone and if it doesn't affect even a minor deficiency, which have a tendency to grow into majors. Go ahead.

Mr. WEEMS. Secondly, working through that, we need to make sure that we educate the surveyors, and we have new guidance to surveyors to improve their accuracy on items like pressure ulcers, incontinence, quality assurance, making sure that they are getting the medications they need. We are educating the surveyors to make sure that that happens. Thirdly is the Quality Indicator Survey. That will produce greater consistency across surveys. You can see that we are undertaking that effort. We will be in eight States this year and continuing to expand that effort. That will give us more substantial consistency across State surveys.

Mr. STUPAK. Sure, and Dr. Kramer said that 80 percent of the people who participated in the Quality Indicator Survey were happy with it. They thought it was much more concrete and it gave them more because if you go back to the GAO report, the one that was released today, GAO found the reasons for surveyors not iden-

tifying problems is that they lack, A, investigative skills, and B, the ability to integrate and analyze the information they collected to make an appropriate deficiency determination. So QIS has to get out there and the Kramer report has to get out there. So in the meantime, since you are going to do an action plan, what does CMS do to train these surveyors who are taking these surveys if we are missing all this? What are we doing? You said only a few States are using QIS so how current is CMS going to help surveyors using the current system or should we start switching over to QIS right now?

Mr. WEEMS. Well, we move QIS at a pace according to the budgetary resources that we have, but what we are doing is continuing to educate surveyors to produce a more consistent result until those States come into the QIS program.

Mr. STUPAK. Well, then, the QIS, is it a budgetary problem? I think Dr. Kramer said it would be $20 million. The healthcare folks, American Health Care Association, were a little reluctant to say they would put in their private money to help implement that $20 million to get it throughout but is $20 million really the issue? I think even Mr. Shimkus said the numbers we deal with, $20 million doesn't seem too far of a stretch when you are talking about 1.8, 1.5 million people in nursing homes.

Mr. WEEMS. If I could adjust your question slightly, it would be, is the budget a rate-limiting factor, and I would say if you said today, Mr. Weems, we are going to give you $20 million and we expect to have this implemented in a year, I would resist that for the reason that you roll something out nationally, let us proceed carefully. We have learned a lot from these eight States as we go along. We can pick up the pace but this isn't a matter of going nationwide right away.

Mr. STUPAK. But at the same time, if we say Mr. Weems, here is your $20 million, you contract with States to do the surveys, don't you? And therefore, the States would be getting it. You would have the resources then to do adequate surveying and do the training necessary. I guess I wouldn't be thinking that $20 million would just go right to CMS and stay there but would go to the States because you contract out to do the surveys and then you follow up either by telephone or a couple weeks later the Federal surveyors go in there, right?

Mr. WEEMS. Sure.

Mr. STUPAK. So it wouldn't be that much of a burden then to—you already have a system in place, but I guess the part that really bothers us, $20 million but we want to make sure the $20 million is going to surveyors who are doing a QIS and it is being done accurately and they have the training to do it so we can get accurate data and then it is going into one central location so we can all find it.

Mr. WEEMS. And to make sure that we are doing QIS properly. As I said, we are learning as we go. I really would want to think carefully about doing 32 States, you know.

Mr. STUPAK. Well, if you have had QIS since last December, in your budget then, did you ask for money to help train people to implement QIS?

Mr. WEEMS. We do have budgetary resources in our budget request for QIS. It is a rate of two or three States a year but——

Mr. STUPAK. That is all, right? Two or three States?

Mr. WEEMS. Right. But having raised that, for the last 4 years in a row, CMS has not even achieved the President's budget level for survey and certification and that is the budget that comes out of.

Mr. STUPAK. Mr. Shimkus?

Mr. SHIMKUS. Just a brief one. I just want to change kind of the focus to this issue that you deal with Special Focus Facilities, and we got 134 such entities in the program. My perception is, there is a time lag when they are identified, then you finally say let us bring in all these people to fix this if it becomes Special Focus First of all, is that a wrong observation, and if it is not, why don't we just go after the root cause right when we have identified them in this Special Focus arena?

Mr. WEEMS. When Special Focus Facilities are selected, they are selected off of candidate lists that the States give us. These are chronically underperforming facilities. Once they enter the Special Focus Facility designation, they are then surveyed at twice the rate that a normal facility is, and given how they perform on those——

Mr. SHIMKUS. OK. But the issue is, why not send in—why don't you just try to identify the root cause then? I mean, they are already identified as problematic. Why not just say let us go in and special investigative—yeah, I was going to say a SWAT team evaluation.

Mr. WEEMS. When we have done root cause analyses and we have worked with facilities to do that before, it can be quite expensive.

Mr. SHIMKUS. OK. And I think we would—so you think by upping the investigations, you move them into compliance. You have the experience. I don't. You move them into compliance by saying OK, we are going to come around and if you don't, then we are going to bring in all these people to try to find the root cause.

Mr. WEEMS. They are going to be on either a path of improvement where they will graduate or they have shown some improvement but they will still stay in the Special Focus Facility program and continued to be surveyed every 6 months or they will be on a path to termination. That is what it means to be in that designation. We have also taken the step of putting the Special Focus Facility designation on the Nursing Home Compare Web site. If you go to the Nursing Home Compare Web site, you can see that that home is on the Special Focus Facilities. You can also see what the most recent update is, whether or not they are on a path to improvement or whether they are on the road to termination.

Mr. SHIMKUS. And my final question is, in the 2008 Action Plan for Nursing Home Quality, CMS cites expansion of the collaborative focus facility project. What is this project and what homes does it cover?

Mr. WEEMS. In the most recent scope of work for the Quality Improvement Organizations, we have designated special facilities with specific problems for the Quality Improvement Organizations to work with those facilities to produce specific quality outcomes in those facilities.

Mr. SHIMKUS. And this kind of wraps up around the initial question: Why not use these Quality Improvement Organizations more extensively? Is it cost?

Mr. WEEMS. You know, Quality Improvement Organizations have wide missions, including the PPS hospitals for which we gave them specific quality improvement assignments this year as well, so they have a very broad mission that extends just beyond nursing homes.

Mr. SHIMKUS. That is all I have, Mr. Chairman.

Mr. STUPAK. Well, thanks. Let me just summarize, and if I may, with this question. We have an ownership issue. We have deficiency. We have the GAO report again coming out today saying we are not doing very well at surveys, it is still deficient. OIG says the same thing. We talked about $20 million. If we got 1.7 million people in nursing homes or centers, that is about $10 per person. I don't think that would be a hurdle we should overcome because the problem is, as I see it, and it has been a while since this committee has done oversight in this area, but still, when you listen to Mrs. Aceituno about what happened to her husband, there are reports of death, you have people with wounds with maggots in dead flesh, I just see the Kramer report which sort of outlines, sort of like a blueprint for enforcement to improvement the survey system and it is 15, 17 months, nothing is happening. While we are not doing anything or rolling that out because you don't have an action plan, I think the Kramer report sort of gives you the action plan because we have people suffering and we want to get this taken care of, and the industry as a whole looks pretty good from what I am hearing today, but there is that 20 percent that is repeat in and out of deficiencies, and I think we need to do a quicker job of taking care of it, and if it is $20 million, I am sure when you present it to people that it is 10 bucks, maybe even the private nursing homes will kick in to get this thing resolved.

I think we have to have more action as opposed to inaction and maybe Congress shares some of that responsibility. Like I said, it has been 31 years since this committee looked at it, so I plan on staying on top of it. We will have another hearing, I know, we are already talking about to follow this up so we would hope you will take this Quality Indicator Survey, the Kramer report, get your action plans done, let us get it implemented and let us get a database we can draw from. I think that is a fair assessment of where we have been today.

Any comments on that, Mr. Weems?

Mr. WEEMS. I thank you for your comments. The way that I would characterize, first of all, what I have learned today, is that improvement is multi-factorial. The chief counsel to the Inspector General I think made an interesting suggestion about maybe doing a demonstration project that really reaches to the far reaches of ownership. Let us see if that makes a difference. I think we need to look—one of the things that we haven't spent time talking about today are financial incentives in nursing homes. I think we need to move to the ability to pay for quality. Right now, under Medicare, we pay under a prospective payment system. Our payment system is quality neutral. It doesn't make a difference. We need to change that. We need to change that in the Medicaid world. We need more consistency among the surveys. We need all of those

things, Mr. Chairman, so I agree with you, we shouldn't concentrate on a few things. We make progress only by moving on many fronts.

Mr. STUPAK. Well, moving on many fronts, and it is not just you but some of the frustrations I see is, like I said, the 1998 report, the OIG report, we got another one out today, it seems like this has repeated itself for the last 10 years and I am sure it is before that too. Money tied just to quality, what I am concerned about is people who do the work, those dedicated workers who work day in, day out to take care of our loved ones, who we entrust to them, these workers, a lot of times they don't see that money. Many of these jobs are minimum wage-paying jobs in certain States. I would look at or I would suggest that if you are going to target a State for a demonstration project, we should be able to put more than one State as a demonstration project, Number one. But if we do, why don't we do a demonstration project on a bad chain? We know they are out there. Maybe we have an opportunity now with our Carlyle Group buying out the Manor, which always had a good reputation, maybe that is a demonstration project we could do to make sure the quality stays up or improve underneath the Carlyle Group because there is a concern, as we heard today, that it is a $5.5 billion investment, they are going to have to recoup their investment. So if you tie money to quality, hype the reports on quality so we reap more money to pay down that $5.5 billion debt, but in reality, because we don't have strong surveys or accurate surveys who aren't catching deficiencies, patient care is leaving or going down, not up.

We appreciate you being here. We appreciate the interaction we have had with you and we look forward to working with you, and we would like to see the Kramer report and the QIS rolled out sooner. If it's a matter of resources, I think this committee on both sides would like to see the resources because you have heard every one of us have been affected by a family member or someone who is at these centers or nursing home facilities and we want to make sure that they have the quality care that we all think they know and deserve. Thank you.

That concludes all questioning. I want to thank all of our witnesses for coming today and for their testimony. I ask unanimous consent that the hearing record will remain open for 30 days for additional questions for the record. Without objection, the record will remain open.

I ask unanimous consent that the contents of our document binder be entered into the record. Without objection, the documents will be entered into the record.

That concludes our hearing. Without objection, the meeting of the subcommittee is adjourned.

[Whereupon, at 2:38 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

STATEMENT OF HON. JAN SCHAKOWSKY

Thank you very much, Mr. Chairman. I want to also welcome our witnesses and thank each of them for being here today.

Mr. Chairman, it has been far too long—over 20 years in fact—since we as a Congress turned a speculative eye towards the nursing home industry. But now, just as we did prior to passing OBRA '87, we must recognize the changing tides in this

industry and act to ensure the health and safety of all residents who entrust their health and their lives to nursing homes.

Though some progress has been made in improving quality since OBRA '87, many of the same concerns we had back then stubbornly persist in communities all across this country and in fact, new and very serious concerns have come to light over the past few years.

Between 1985 and 1990, I served as the Director of the Illinois State Council of Senior Citizens, and in that role I fought for better prescription drug prices and benefits for seniors as well as financial protection for seniors and their families. I also became keenly aware of the myriad of abuses inflicted upon far too many of our family members and friends who live in nursing homes.

I am sure that we will hear in greater detail how and why those abuses occur from some of our witnesses, so I want to specifically mention my concerns about the changing structure and changing face of the nursing home industry over the past few years. Not only has the number of national chains increased to a point where over half of nursing homes are part of a chain, but a new player has entered the ownership scene: large private equity firms.

According to a New York Times article published in September of 2007, these private groups have agreed to buy 6 of the Nation's 10 largest nursing home chains in recent years. Research from the same article found that at 60% of homes bought by large private equity firms from 2000–2006, managers cut the number of clinical registered nurses—in some cases, by so much that they were below the level required by law.

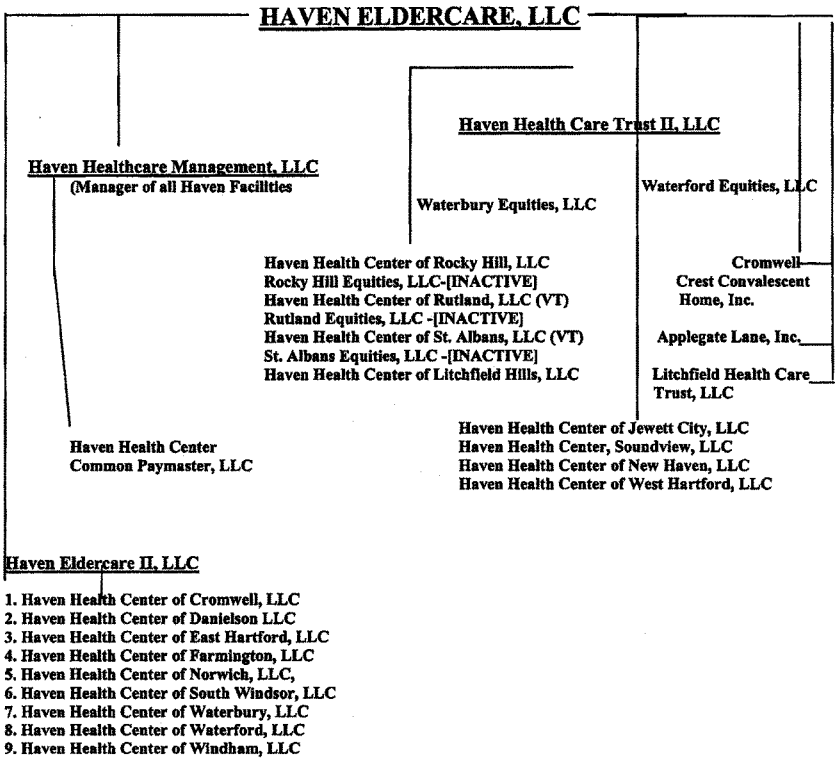
This is a serious indicator of the decline in care at these facilities, and unfortunately, staffing is just one area that has suffered under this new regime of private investment company ownership. The use of physical restraints, poor nutrition, and neglect are just some of problems found at higher rates in private equity facilities than publicly-owned or nonprofit facilities.

But the fact is, we need more information from all nursing home facilities. Though there are some that provide quality care, there are others that most certainly don't. That's why I am working with my colleague on the Ways and Means Committee, Chairman Stark, on companion legislation to the bipartisan proposal in the Senate that I think will greatly improve oversight of the industry. By increasing transparency and accountability across the board, but also specifically of ownership structures, I believe this legislation will mark a new turn in ensuring quality care for nursing home residents.

Mr. Chairman, I look forward to working with you and our colleagues on the Committee on this legislation in the future, and I thank you for giving this Subcommittee the opportunity to take a closer look at these very important, very troubling issues.

HAVEN NURSING FACILITIES AND AFFILIATED ENTITIES ORGANIZATIONAL CHART

(Active Entities)



Haven Eldercare II, LLC

1. Haven Health Center of Cromwell, LLC
2. Haven Health Center of Danielson LLC
3. Haven Health Center of East Hartford, LLC
4. Haven Health Center of Farmington, LLC
5. Haven Health Center of Norwich, LLC,
6. Haven Health Center of South Windsor, LLC
7. Haven Health Center of Waterbury, LLC
8. Haven Health Center of Waterford, LLC
9. Haven Health Center of Windham, LLC

HAVEN ELDERCARE OF NEW ENGLAND, LLC

Haven Health Center of Warren, LLC (RI)
Haven Equities of Warren, Rhode Island, LLC (RI)
Haven Health Center of Pawtucket, LLC (RI)
Pawtucket Equities, LLC (RI)
Haven Health Center of Greenville, LLC (RI)
Greenville Equities, LLC (RI)
Haven Health Center of Coventry, LLC (RI)
Coventry Equities, LLC (RI)
Haven Health Center of Chelsea, LLC (MA)
Chelsea Equities, LLC (MA)
Haven Health Center at Seacoast, LLC (NH)**
Hampton Equities, LLC (NH)**

**12 ½% of Haven Health Center at Seacoast, LLC and Hampton Equities, LLC are owned as follows: Daniel Trahan: 4.167%; David Trahan: 4.166%; Eileen (Trahan) Piet: 4.167%

HAVEN ELDERCARE OF NEW HAMPSHIRE, LLC

Haven Health Center of Derry, LLC (Stockholder of)
Derry Equities, LLC (INACTIVE]
(Ferretti's Nursing Home, Inc.)
D/B/A Haven Health Center of Derry

HAVEN HEALTH CENTER OF CLAREMONT, LLC

LONG HILL EQUITIES, LLC

245 Long Hill Road Associates, LLC Scrambler's, LLC

LIGHTHOUSE MEDICAL, LLC

Lighthouse Environmental, LLC Lighthouse Medical Supply, LLC

Definitions

SNFs Skilled Nursing Facilities are Medicare certified facilities that provide extended skilled-nursing or rehabilitative care under Medicare Part A. Facilities that are not SNFs are not reimbursed under Part A, but may be reimbursed for some items and services under Part B.

PPS Prospective Payment System. Before the BBA of 1997, Medicare paid SNFs based on reasonable costs, as reflected in their annual cost reports. Since 1998, SNFs are paid under PPS. The daily rate is supposed to cover all costs of furnishing routine, ancillary, and capital-related costs to the Medicare beneficiary for skilled nursing care. Some states still use a cost-based reimbursement system for Medicaid reimbursements; others use a form of PPS.

MDS Minimum Data Set. MDS was developed as a tool for clinical evaluation and guidance for nursing home patients' care plans. Under PPS, the MDS is also now used to set RUG payment rates for each SNF resident.

OSCAR CMS' Online Survey, Certification and Reporting system. Tracks nursing home survey results (has some limited ownership data).

PECOS CMS' Provider Enrollment Chain and Ownership System. CMS contractors started inputting Medicare provider enrollee data into PECOS in 2002. Only 72% of nursing homes are in PECOS. Currently, providers fill out Form 855, the provider enrollment form, by hand and contractors manually input the data. CMS is working on enabling Medicare providers to enroll and update their information electronically.

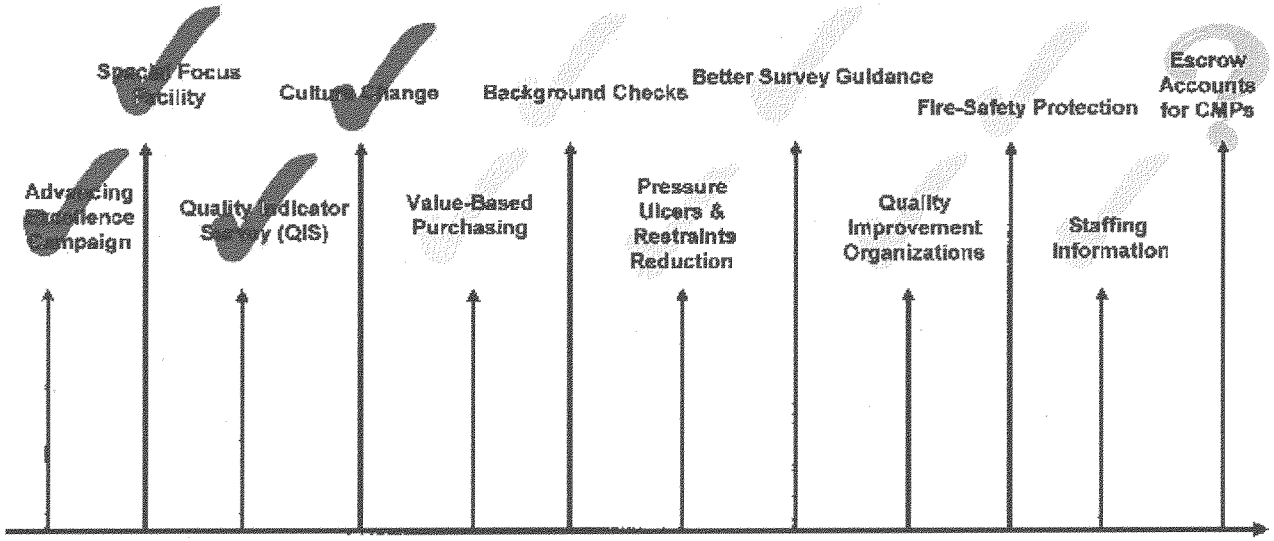
CMPs Civil Money Penalties. OBRA 87 authorizes CMS to impose CMPs ranging from $50 to $10,000. CMPs can either be per day or per instance; the fine amount can vary depending on the scope and severity of the deficiency.

QIS Quality Indicator Survey. The new facility survey tool developed by Andy Kramer intended to reduce subjectivity and variability in the survey process. CMS is rolling QIS out to states by training surveyors on the process.

QMs Quality Measures are CMS' publicly reported measures documenting outcomes nursing home residents. They were designed to provide fair measurement of facility quality track nursing facility residents who have and are at risk for specific functional problems needing further evaluation.

CMS Nursing Home Quality Milestones[1]

2007-2008



[1] For additional information see CMS' Nursing Home Action Plan published each year at http://www.cms.hhs.gov/CertificationandCompliance/12_NHs.asp#TopOfPage.

Additional Written Questions
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations Hearing
On
"In the Hands of Strangers: Are Nursing Home Safeguards Adequate?"

May 15, 2008

The Honorable John Dingell

Special Focus Facilities:

1. **In response to a question from Chairman Stupak about the Special Focus Facility (SFF) program, Acting Administrator Kerry Weems stated, "Within the resources that we have right now, it is something that we would look to expand."**

   a. **How many full-time equivalent Centers for Medicare & Medicaid Services (CMS) and contractor staff are currently assigned to work on the SFF program?**

   Answer: The Centers for Medicare & Medicaid Services (CMS) and States visit nursing homes on a regular basis to determine if the nursing homes are providing the quality of care that Medicare and Medicaid requires. These "survey" or "inspection" teams will identify deficiencies in the quality of care that is provided. They also identify any deficiencies in meeting CMS safety requirements (such as protection from fire hazards). CMS created the Special Focus Facility (SFF) program in 1998 as one of the initiatives of the Nursing Home Oversight and Improvement Program. The purpose of the SFF program was to decrease the number of persistently poorly performing nursing homes by focusing more attention on nursing homes with a record of poor survey performance. In January 1999, CMS directed State survey agencies (SAs) to conduct two standard surveys per year for each SFF instead of the one required by law. CMS and state survey agencies work collaboratively together on the SFF program as part of the survey and certification program's commitment to ensuring nursing homes meet Federal standards of care. To date, CMS continues to implement nursing home quality pilot projects and initiatives through its 2008 action plan. This action plan is available on the CMS website at:
   http://www.cms.hhs.gov/CertificationandComplianc/12_NHs.asp#TopOfPage

   As an administrative initiative, the SFF program was created out of existing resources and funds allocated to the Medicare and Medicaid Survey and Certification program through the President's Budget. The number of nursing homes in the program was last expanded when there was an increase in S&C funding in 2005.

   Resources to carry out the SFF program are broken out by function: (a) central office, (b) regional office, and (c) States. At CMS central office, approximately 1.5 FTEs are required for overall direction-setting, policy and communications; reporting and monitoring functions; posting SFF information on the CMS website; providing technical assistance and guidance (including potential systems improvement agreements with nursing homes under

enforcement action; and developing SFF replacement lists. Each RO has the responsibility for tracking progress on SFFs and providing technical assistance and oversight of States. Regional Offices may be organized in a variety of ways—some are structured by a State representative—while others are organized by function. In either case, we estimate an aggregate of 2.6 FTEs for all Regional Offices. In total, then, we estimate that 4 CMS full-time equivalent employees work on the SFF program. We cannot say how much of this FTE time would be spent on the same nursing homes in the absence of the SFF initiative, given that these SFF facilities have above-average problems.

With regard to State survey costs, we estimate the aggregate annual cost of the additional surveys of SFF nursing homes (twice per year rather than just once) to be about $2.1 million (at a rate of a little over $15,000 per survey multiplied by 135 SFFs).

b. Have CMS and/or any States analyzed the average percentage of State surveyors' time spent on nursing homes that meet CMS' criteria for designation as a SFF (as opposed to the smaller number that the States select for the SFF list), compared to time spent on other nursing homes and other types of surveyed entities? If so, please provide that analysis.

Answer: CMS requires that SFF nursing homes be visited in person by survey teams twice as frequently as other nursing homes. For all nursing homes, survey teams conduct in-person, on site visits an average of once a year. In some circumstances, a poor performing nursing home requires a follow-up survey or a complaint investigation. States submit a monthly status report listing any surveys, revisits, or complaint investigations of SFF they had conducted in that month.

Generally, we find that poorer performing nursing homes that are not designated as a SFF require a larger percentage of a surveyor team's time. However, there has not been any special study of the amount of time these nursing homes require in the absence of an SFF initiative, or the amount of time SFF nursing homes use compared to other nursing homes.

c. Please provide any cost analyses or estimates CMS has performed with respect to potential expansion of the SFF program to include more facilities.

Answer: Within the past year, CMS has implemented a series of improvements to address the problem of chronically under-performing nursing homes, such as SFFs. In 2005, for example, we increased the number of SFF nursing homes by 30% and strengthened enforcement. In November 2007 we began publishing the names of SFF nursing homes that had failed to improve significantly. In February 2008 we added all other SFF nursing homes in a format that allows consumers to distinguish between nursing homes that were improving compared with those that are not. In April 2008 we added cross-links between the individual nursing home pages on our *NH Compare* website with the full SFF list. In terms of projecting the cost of expanding the number of SFF facilities, a reasonable estimate at this point in time would be (a) $15,000 for every nursing home added and (b) 1.0 CMS FTE for every 50 nursing homes added.

Quality Improvement Organizations:

2. **How will CMS ensure that Quality Improvement Organizations (QIOs) have adequate expertise and professional experience to help nursing homes improve their performance?**

Answer: CMS evaluates QIOs proposals in part by assessing their expertise, professional experience, and staffing plans to assist nursing homes and other providers. .

3. **How will CMS ensure that QIOs target their efforts at helping those nursing homes with the most survey deficiencies or poorest Quality Measure (QM) scores, rather than focusing on better-performing facilities?**

Answer: CMS identified Nursing Homes that had exhibited the greatest opportunity for improvement and compiled these facilities into a list which was made available as attachment J-17 of the RFP that was provided to the Quality Improvement Organizations.

The 9th SOW Patient Safety theme specifically focuses on those facilities that have performed lower than expected in specific publicly reported quality measures. For example, nursing homes with pressure ulcer rates of 20% or greater (the goal is 6%, national average is ~12%) in two of three recent reporting quarters were targeted for improvement. Nursing homes with physical restraints rates of 11% or greater (the goal is 3%, national average ~5%) in two of three reporting quarters were similarly targeted. These lists were designated "J-17" for the purposes of the 9th SOW.

In addition, this SOW includes a new component – Nursing Homes in Need (NHIN) – that is a collaborative effort between the Center for Medicaid and State Operations and the Office of Clinical Standards and Quality. QIOs receive a nursing home assignment from a list of homes – Special Focus Facilities (SFF) and other nursing homes that have serious quality issues, including substantially more survey deficiencies. Some homes have been on this list for over three years; QIOs will be working with one of these homes in their state in the first year of the contract. It is anticipated that a QIO will receive a new assignment at the start of each year of the contract (three over three years).

4. **How will CMS increase the number of chronically under-performing nursing homes that receive assistance from QIOs?**

Answer: CMS will work to increase the number of chronically under-performing nursing homes receiving assistance by targeting those providers that have been identified as poor performers for the QIOs to recruit from.

In contrast to prior scopes, the 9th SOW focuses its efforts on those nursing homes that are in the most need of intervention in quality improvement. QIOs have been provided lists of those homes with poor performance (as described in (#3 above) from which they must recruit. Within

the Patient Safety theme, 1100 nursing homes with high pressure ulcer rates and 1232 nursing homes with high physical restraints rates are targeted for improvement; this is in addition to the 169 nursing homes being assisted by QIOs during the 9th SOW under the Nursing Homes in Need project.

5. **For each of the 53 jurisdictions in which QIOs operate, how many nursing homes that meet CMS' criteria for designation as a SFF are currently assisted by QIOs? How many nursing homes are on the SFF list in each such jurisdiction? How many nursing homes not included on CMS' SFF candidate list for that State are being assisted by a QIO?**

Answer: Nursing home recruitment for the 9th scope of work is still ongoing, thus that information has not yet been made available. Under the QIO confidentiality statute and regulations, QIOs cannot reveal to CMS the names of the Special Focus Facilities they will assist. Our response to question #6 provides more detailed information about our privacy and confidentiality restrictions.

Aside from this new initiative – Nursing Homes in Need – the Quality Improvement Organization program under the 9th SOW does not involve additional activities related specifically to homes designated as SFF. It is possible that a QIO organization, under another component of the 9th SOW Patient Safety theme, may work with a SFF to improve quality of care by reducing high-risk pressure ulcers and restraints.

6. **Do QIOs report to CMS the identity of SFFs they are assisting? If not, please provide the legal and/or policy justification for withholding such information from CMS, and explain how the Agency can perform its contractor oversight responsibilities of the SFF program without such information.**

Answer: The identities of the SFFs and other nursing homes and providers that the QIOs will assist through their 9th SOW activity are available to be known via on site visit and or virtual on site visit portal (electronic) for purposes of contract deliverable verification and evaluation. QIOs are not permitted to release this information to CMS and CMS is not permitted to take possession of this information as in both cases it would be a violation of 42 CFR 480.140. Analyses and data processing of this and related information is performed by QIOSCs that are, in themselves, QIOs and this data is shared with the QIO as well as CMS (albeit with CMS in a redacted form to protect QIO confidential information as per regulation). QIOs, by statute (SSA Sec.1160 (a)) are not subject to FOIA and are unique in that regard, which makes it critical that the protected data noted above not leave its protective ownership and thus become subject to FOIA by having it come into the possession of CMS. A Provider (i.e., Nursing Home) may consent to or request that a QIO release their identity to an identified third party.

7. If CMS believes that it cannot incorporate adequate confidentiality safeguards to promote voluntary participation in QIOs' quality improvement initiatives, what legislative or regulatory changes does CMS recommend to provide such safeguards?

Answer: CMS currently has confidentiality safeguards which help promote voluntary participation in most QIO quality improvement initiatives; however these safeguards have been criticized as overly restrictive. Therefore, regulatory changes to improve the availability, protection and utilization of QIO data are currently under consideration by CMS. These changes could further promote voluntary participation in quality improvement initiatives if there is a balance between data availability and disclosure and provider and practitioner concerns about the risks of disclosure, including the potential for increased civil litigation.

8. How will CMS collect more complete and detailed data on the interventions QIOs are using to assist nursing homes?

Answer: CMS is using the pressure ulcers and restraints measures from the MDS systems to evaluate QIO technical assistance. Additionally, CMS will assess nursing home satisfaction with QIO assistance through a QIO (or subcontractor) administering a questionnaire to nursing homes working with QIOs. CMS will receive aggregate information about nursing home satisfaction from the QIO (or subcontractor).

Under the 9th SOW, QIOs are responsible for providing quarterly reports that summarizes effectiveness of QIO interventions. In addition, the Patient Safety support contractor is tasked with tracking QIO progress and identifying high performers and best practices.

9. How will CMS identify a broader spectrum of measures than QMs to evaluate changes in nursing-home quality?

Answer: The current Quality Measures are the 17 quality measures reported on Nursing Home Compare. In addition, CMS now computes other quality indicators that are shared with the facilities and the survey and certification teams, but not reported publicly.

CMS is on the threshold of fielding data collection instruments that much more adequately reflect the array of issues that affect the clinical course of nursing home residents. Once the Minimum Data Set (MDS) 3.0 is in the field (starting in October 2009), CMS will have the data needed to generate much more useful quality measures.

For example, now CMS reports the prevalence of all pressure ulcers at particular points in time for three populations (short-term after-hospital residents, low-risk long-term care residents, and high-risk long-term care residents). While they were the best measures available a decade ago, these measures are quite unresponsive to quality processes and reflect only a narrow part of the spectrum of good prevention and healing of pressure ulcers. The new data set and collection schedule for MDS 3.0 will enable testing a dozen new measures: risk assessment and response, healing by stage, incidence by stage, and population rates.

Once those are developed and tested, CMS can field and report a much richer spectrum of measures, and this strategy affects most components of high-quality nursing home care. The new MDS 3.0 will have much more responsive and accurate measures in diverse areas including depression, delirium, symptoms, and discharge planning. It is not possible at this time to predict how many of these will be appropriate for public reporting, but the potential array is much broader and more illuminating than the field has previously had available.

10. If any of the 53 QIOs are not assisting every nursing home that meets CMS' criteria for designation as an SFF, please explain why, and identify those jurisdictions in which QIOs are not providing such assistance.

Answer: The QIO program is currently structured to implement proven effective interventions to improve quality of care received by Medicare beneficiaries. The NHIN project is a new component that will be implemented under the 9th SOW and is restricted to one nursing home assignment from the SFF list for each QIO (state) for each of the three years of the contract.

Nursing home recruitment for the 9th scope of work is still ongoing, thus the recruitment information has not yet been made available. Under the QIO confidentiality statute and regulations, QIOs cannot reveal to CMS the list of Special Focus Facilities or other providers they will assist, as previously mentioned in this response (see question #5).

11. For any and all SFFs that have requested but not received assistance from QIOs, please identify those SFFs, and provide the reasons for such denial in every case.

Answer: Nursing home recruitment for the 9th scope of work is still ongoing, thus that information has not yet been made available. Under the QIO confidentiality statute and regulations, QIOs cannot reveal to CMS the list of Special Focus Facilities or other providers they will assist, as previously mentioned in this response (see question #5).

12. How will CMS ensure that the QIOs share with each other information and expertise concerning best practices, lessons learned, and most effective intervention strategies in connection with nursing-home assistance?

Answer: CMS uses several strategies to allow QIOs to disseminate information, and to spread best practices to all QIOs for nursing homes and other provider settings. We allow QIOs to post intervention documents describing intervention strategies on the QualityNet website for public dissemination. We also provide a listserv for QIOs to submit questions to CMS and support contractor experts, and to share information on interventions and best practices. CMS and its support contractors also facilitate information sharing through on-site annual meetings with QIOs, periodic teleconferences, and educational sessions through internet and videoconference.

Under the 9th SOW Patient Safety theme, each QIO will also utilize the voluntary efforts of National Quality Improvement Leaders (NQIL) which will take the lead on QI efforts and communication. The NQIL will attend meetings (up to three a year) to share best practices and updates on change packages. The Patient Safety support contractor will also play an important role in ongoing communication with all the QIOs in regards to sharing best practices

information. To this end, the support contractor will make use of conference calls, listservs and trainings.

13. How will CMS ensure that QIOs are responsive to suggestions from nursing homes with respect to strategies and interventions that are most effective (e.g., on-site visits) in assisting nursing homes to improve their performance?

Answer: QIOs undergo ongoing monitoring by Project Officers to assure that contract requirements are being met. CMS uses performance-based service contracting to evaluate QIO performance on improving nursing home quality measures included in the QIO statement of work. These performance requirements are stringent, so QIOs must be responsive to feedback from nursing homes and other providers to refine and improve their strategies and interventions. Additionally, CMS also requires QIOs to achieve minimum targeted thresholds of satisfaction at two points of the three-year contract period from nursing homes working with them. This will reflect the quality and effectiveness of Root Cause Analyses and Action Plans as well as overall performance of the QIO.

14. How will CMS improve its ability to measure the impact of QIOs on nursing-home quality?

Answer: CMS plans to initiate a rigorous, independent evaluation of the impact of QIOs on all major care settings including nursing homes in the late summer, and this evaluation will include a quantitative estimate of the impact of QIOs under the 8th scope of work and a separate estimate of their impact under the 9th scope of work. The impact estimates will be based on a comparison of providers who received services from QIOs to statistically identical providers who did not receive such services. CMS will receive only aggregate results from this evaluation for program evaluation purposes. The evaluation will also include a qualitative assessment of the process by which QIOs provide services to providers. This process analysis will provide CMS with recommendations for improving the effectiveness of the services QIOs offer to providers.

15. Is CMS directing all QIOs to focus intensive assistance on Quality Measures that reflect homes' greatest quality-of-care challenges? If not, please explain why.

Answer: CMS' has developed measures in Physical Restraint use and the occurrence of Pressure Ulcers in nursing home facilities due to the need for improvement in both of these areas, made evident by the variation that is shown in data from these areas of concern between states. These two measures had also shown the greatest improvements in past scopes, indicating that great improvements are possible in these areas with more intensive focus. Our goal is to improve quality-of-care by focusing on issues that are affecting a wide number of nursing homes on a national level.

16. What types of data and data sources (e.g., CMS, State agency, contractor, independent entity) do QIOs use to identify and target nursing homes for assistance?

Answer: For the 9th SOW Patient Safety theme, the data source for pressure ulcers and physical restraints is the Minimum Data Set (MDS), which also is the data source for publicly reported

quality measures on Nursing Home Compare. The NHIN program, which pertains to the SFF, involves additional data related to survey compliance, beneficiary complaints and quality measures.

17. When a QIO identifies a nursing home or rehabilitation facility admission or services as medically unnecessary, what steps are taken to recover any overpayment involved? How many overpayments have been recovered as a result of referrals by QIOs to other CMS contractors?

Answer: CMS contracts with the Medicare Administrative Contractors (MACs), Carriers, and Fiscal Intermediaries (FIs) to oversee and monitor the Medicare benefit payments. FIs and MACs determine the appropriateness of admission and medical necessity in the nursing home and rehabilitation settings. They also recover the overpayments consistent with the Agency's policies and procedures. Quality Improvement Organizations (QIOs) play a role in these particular settings when a beneficiary complains about the quality of health care services and/or when the beneficiary wishes to appeal a notice for the termination of health care services. If a QIO becomes aware of an overpayment, they'd refer the overpayment to the FI or MAC. Although FIs and MACs are responsible for recovering overpayments, they do not track the recovery of overpayments by referral source.

18. How many QIO corporate entities are related to other CMS contractor entities (e.g., a subsidiary or parent of a Program Safeguard Contractor (PSC) or a Medicare Affiliated Contractor (MAC))? Please identify all QIOs having corporate relationships with other CMS contractors.

Answer: Please see the chart below. The relationship exists because the QIO is a subcontractor.

Subcontractor Name: (QIO)	Georgia Medical Care Foundation (GMCF)
Sub-Contract Award Amount: (including all options)	$213,066.53
Period of performance: (including all options)	9/13/2007-3/31/2009
Short Description of services:	(2006 Secondary Validation Contract (SVC)) conducting independent reviews of hospital inpatient, hospital outpatient, and physician medical records as submitted from the Initial Validation Contractor (IVC)
Name of prime contractor:	Healthcare Management Solutions (HMS)

Subcontractor Name: (QIO)	Colorado Foundation for Medical Care
Sub-Contract Award Amount: (including all options)	$1,053,930
Period of performance: (including all options)	9/25/2006 -12/31/2009
Short Description of services:	Subcontractor to a Qualified Independent Contractor (QIC). Provides reconsideration work and quality assurance services
Name of prime contractor:	First Coast Service Options

19. Are PSCs entitled to obtain data, reports, or other information from QIOs to assist the PSCs in their analysis of program integrity issues with respect to nursing homes? If not, why not?

Answer: Because PSCs are CMS contractors and due to the nature of their specific duties as such they are entitled to obtain data, reports or other information from QIOs to assist the PSCs in their analysis of program integrity issues with respect to nursing homes insofar as the data does not violate disclosure prohibitions identified in 42 CFR Part 480. See answer number 5 above for more information. For example, the released data to a PSC could not explicitly or implicitly identify a beneficiary, a practitioner (without his/her consent) or, in the case of an SFF, a Provider (without the entity's consent). Aggregated data and reports containing trends and patterns as well as generalizations and interpretations on the quality of health care that identify particular institutions are permissible. These disclosures would be subject to the procedures for disclosure and notice of disclosure specified in 42 CFR 480.104 and 105.

20. What are CMS' guidelines to QIOs with respect to the reporting, to appropriate legal authorities and/or surveyors or ombudsmen, of imminent patient harm or threats to - resident safety when a QIO had identified such situations in the course of its activity?

Answer: CMS' guidelines are based on Section 1160(a) - (d) of the Social Security Act and 42 CFR §§480.105, 480.106, and 480.138. These provisions require that QIOs disclose certain confidential information to Federal and State public health agencies upon request and in cases in which the QIO has a reasonable belief that there may be a substantial risk to the public health, and upon request or at the QIOs discretion to State and Federal licensing bodies responsible for the professional licensure of a practitioner or a particular institution.

Program Integrity:

21. Is CMS directing any of its contractors, including but not limited to the PSCs, to analyze and detect chain-wide or facility-level upcoding of Resource Utilization Group codes?

Answer: CMS' program and fiscal integrity oversight efforts work to ensure that Medicare benefit payments are accurate and the services are reasonable and necessary. CMS contracts with the Medicare Administrative Contractors (MACs), Carriers, fiscal intermediaries (FIs) and the Program Safeguard Contractors (PSCs) to oversee and monitor the Medicare benefit payments as well as other program functions. Reviews of the skilled nursing home prospective payment system (SNF PPS) payments to providers are conducted by Medicare contactors and the PSCs. These contractors use data from multiple sources to perform data analyses to monitor payment trends and detect atypical billing trends as policies and payment system changes are implemented.

CMS directs the Medicare contractors to implement medical review programs in order to ensure that payments are made only for those services that are reasonable and necessary. Medical review programs are implemented to verify inappropriate billing concerning coverage and coding errors and to develop interventions to correct the problems. The Medicare contractors are required to develop Medical Review Strategies that prioritize and target their efforts. Through the use of specialized extract tools and software programs for Minimum Data Set (MDS)/Resource Utilization Groups (RUGS) and the progressive corrective action (PCA) process, Medicare contractors are able to identify suspected billing problems, validate suspected

errors with intensified reviews and initiate the appropriate corrective actions to address SNF PPS billing issues.

In addition, CMS directs the Program Safeguard Contractors (PSCs) to perform proactive data analysis and prioritize their investigative workload to identify and address Medicare program vulnerabilities. Before assigning significant resources to examine claims identified as potential problems, contractors perform probe reviews of certain claims to verify that an error exists. If the probe review reveals that an error does exist, the contractor classifies the severity of the problem as minor, moderate and severe. Investigations must have the highest likelihood of referral and administrative actions to protect the Medicare Trust Fund. PSCs are charged to monitor, analyze and detect provider billing trends. CMS and the PSCs share the outcomes the data analysis studies to assist in the development and refinement of the PSC workload. CMS also encourages PSCs to leverage the knowledge gained from CMS, Fraud Alerts and other PSCs to pursue topics of common interest.

The PSCs share the results of their analysis, including SNFPPS and RUGs upcoding, as part of the ongoing CMS/PSC collaborative data conference calls. PSCs are able to consider this information in the implementation of their targeted efforts to address program vulnerabilities.

22. Do the PSCs use data from the Provider Enrollment Chain and Ownership System (PECOS)? If so, for what purposes?

Answer: As part of Medicare Integrity Program, each PSC is allowed access to PECOS and the data collected from the Medicare Enrollment Application (CMS Form 855). The PSCs utilize PECOS data as part of their investigations to help detect relationships or connections with other Medicare providers and have found the information helpful.

23. How many referrals have PSCs made in the past 24 months to the Department of Health and Human Services Office of the Inspector General (OIG) and/or Medicaid Fraud Control Units (MFCUs) in connection with nursing homes? During that same period, how many such referrals have been accepted or declined by OIG and/or an MFCU? During that same period, how many referrals declined by either OIG or an MFCU have been referred to the Department of Justice?

Answer: Over the past 24 months, the PSCs made 35 referrals to the Department of Health and Human Services Office of the Inspector General (OIG) in connection with nursing homes. Cases are initially referred to OIG and are subsequently referred to the Department of Justice (DOJ) as appropriate. Over the past two years, the OIG referred 9 PSC cases to the DOJ. Eleven cases were declined by the OIG and 2 were declined by the DOJ. All of the cases that were declined were declined due to lack of law enforcement resources, except one which was due to a low dollar threshold. When cases are declined and returned to the PSC, the PSC takes administrative action to recoup overpayments.

State Medicaid Agencies are required to refer all cases of suspected fraud, including fraud in connection with nursing homes, to their State Medicaid Fraud Control Unit (MFCU). The number of referrals to MFCUs varies widely across States. CMS has been working on

establishing standards, increasing the number of referrals, and holding States accountable for fraud referrals to the MFCUs.

Pending Reports:

24. Chairman Stupak asked Acting Administrator Weems a series of questions about two reports that are under review by CMS. The first report is titled *Improving Nursing Home Enforcement: Findings from Case Studies* (Contract Number: 500-00-0026-0003). The second report is titled *Evaluation of the Quality Indicator Survey (QIS),* (Contract Number: 500-00-0032, TO#7). You stated, "I would like to have both of those reports out and available this summer." When will CMS release these reports?

Answer: As the Acting Administrator iterated, CMS remains committed to making these two reports available as soon as possible. We anticipate these reports will become available on the CMS Web site in conjunction with the plan for updating the Nursing Home Compare Web site in December 2008.

Integration of and Access to Ownership and Quality Information:

25. Our Committee's investigation revealed that there is a linkage between who owns a nursing home and the quality of care provided by the facility. It is extremely difficult or impossible, however, for the regulators, surveyors, ombudsmen, and law enforcement officials involved in monitoring or enforcing nursing home quality to access Government data on ownership and quality in conjunction with one another. How will CMS facilitate this linkage? How could CMS better use data suggesting problems in nursing home chains to direct further scrutiny to nursing homes in chains that may be problematic? Mr. Weems' answer to Chairman Stupak's questions at the hearing suggested that the principal challenge is ironing out the statistical criteria to determine what constitutes a problem chain. When will CMS develop usable criteria to deal with this problem?

Answer: Regardless of setting or ownership, quality health and long-term care for Medicare and Medicaid beneficiaries is of the utmost importance to CMS. CMS focuses on the quality of care experienced by residents regardless of who owns the facility. Our focus on actual outcomes ensures that Medicare's quality assurance system does not depend on any theory of quality or theory of ownership. Instead, the federal survey and certification system is grounded in what CMS and State nursing home surveyors actually find through on-site inspection; through in-person interviews with residents and staff; through the eyewitness observation of care processes; and through the review of records of care.

As Acting Administrator Weems indicated in his remarks, the critical infrastructure objective is to fully populate our new Provider Enrollment Chain and Ownership System (PECOS) database. Once that is done, it would be possible to design analytic reports and data extracts that would be useful in analyzing trends in the relationship between ownership and performance The extent to which this will be possible will depend on budget and FTE availability.

26. Will CMS support a demonstration project to evaluate the ability of CMS to regulate nursing homes on a chain-wide basis?

Answer: CMS continuously seeks to improve the effectiveness of both the survey process and the enforcement of quality of care requirements. We are increasingly seeking to coordinate our work with the Office of the Inspector General (OIG) where authority exists for taking action on a chain-wide basis.

Implementation of the Quality Indicator Survey:

27. In response to a question from Chairman Stupak about the Quality Indicator Survey (QIS), Acting Administrator Weems stated, "We can pick up the pace but this isn't a matter of going nationwide right away." What is CMS' anticipated timeline for implementing the QIS? What are the barriers, including budgetary or legal issues, preventing CMS from implementing QIS nationwide more quickly? What is CMS doing to overcome these barriers?

Answer: We estimate that nationwide QIS implementation will require about $20 million spread out over a number of years. At present we have been seeking to fund QIS implementation as part of the annual survey & certification operating budget, but that budget is constantly stretched. We have been dedicating about $1-$1.8 million per year to the effort. At this rate, it may be 15-20 years to achieve nationwide implementation.

Nonetheless, CMS has an ongoing commitment to its QIS project. Since February 2008 CMS has added four states to the five states that initially implemented the new, improved Medicare survey process for nursing homes. An additional two States will implement the QIS in the first half of CY 2009. It takes 3-4 years for a state to achieve statewide implementation of the QIS, depending on the size of the State.

CMS views the QIS method as critically important to improve CMS' ability to gather and compare surveyor data among states. Such improved consistency also will provide better data for consumers through the Nursing Home Compare Web site and will give nursing home providers useful information on their performance. The desired improvement supports the need for a system that uses data as a decision-making tool. The purpose is to better focus surveyors on potential areas of concern.

Survey and Certification:

28. How many full-time equivalent surveyors are there in each State, territory, and the District of Columbia?

Answer: Although CMS does not capture full-time equivalents, in FY 2007, the total number of trained and registered surveyors throughout the country, the District of Columbia and territories was 6,715. Seventy-five percent of all surveyors survey nursing homes. The remaining surveyors also survey a multitude of other providers including Intermediate Care Facilities for the Mentally Retarded, Home Health Agencies, End Stage Renal Disease facilities, Hospices,

Hospitals, Critical Access Hospitals, Comprehensive Outpatient Rehab facilities, Outpatient Physical Therapy facilities, Ambulatory Surgery Centers, Rural Health Clinics, Transplant Programs, and Laboratories.

29. What direction does CMS give to surveyors, QIOs, PSCs, and MACs with respect to the identification and cross-reporting of possible financial fraud by nursing homes?

Answer: As part of our Medicare program operations, CMS issues administrative guidance and direction to our contractors related to fraud and abuse issues. The nursing home survey interpretive guidelines includes language for State Agency nursing home surveyors to report suspected provider patterns or practices related to clinical documentation, MDS assessments, or MDS reporting practices that may be indicative of payment fraud or avoidance of the quality monitoring process. Similarly, Quality Improvement Organizations (QIOs) are instructed to refer cases, where they identify possible practice or performance patterns of fraud or abuse situations, to the appropriate Federal or State agency, CMS contractor or CMS program office. Medicare contractors are instructed to refer potential fraud issues to the appropriate entity (Program Safeguard Contractor Benefit Integrity Unit) for review and development.

#	Description	Date
	Background Information	
1	Consumer Reports article, "Nursing Homes: Business as Usual."	September 2006
2	Kaiser Foundation report, "Nursing Home Care Quality: Twenty Years After the Omnibus Budget Reconciliation Act of 1987."	December 2007
	Industry Trends & Ownership Structures	
3	Energy & Commerce Committee Press Release, "Chairmen Dingell, Frank to Meet with Nursing Home Workers to Discuss Private Equity Ownership of Nursing Homes."	10/22/2007
4	New York Times article by Charles Duhigg, "At Many Homes, More Profit and Less Nursing."	09/23/2007
5	New York Times article by Charles Duhigg, "Inquiries at Investor-Owned Nursing Homes."	10/24/2007
6	National Real Estate Investor article by Joe Gose, "A Much Rejuvenated Nursing Home Sector."	09/01/2006
7	HHS Department, Office of Disability, Aging and Long-Term Care Policy Final Report, "Nursing Home Divestiture and Corporate Restructuring."	December 2006
	Quality Improvement & Enforcement	
8	GAO Report, "Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents." (GAO-07-241, Summary Only)	March 2007
9	GAO Report, "Nursing Homes: Federal Actions Needed to Improve Targeting and Evaluation of Assistance by Quality Improvement Organizations." (GAO-07-373, Summary Only)	May 2007
10	GAO Testimony before Senate Special Committee on Aging, by Healthcare Director Kathryn G. Allen, subject: "Nursing Home Reform: Continued Attention is Needed to Improve Quality of Care in Small but Significant Share of Homes."	05/02/2007
11	University of Colorado Health Sciences Center, Division of Health Care Policy and Research report, "Improving Nursing Home Enforcement: Findings from Enforcement Case Studies."	03/22/2007
12	Evaluation of the Quality Indicator Survey Final Report	December 2007
13	Center for Media Advocacy, Inc. report, by Toby S. Edelman, Esq., Senior Policy Attorney, subject: "Nursing Home Decisions of the Department of Health and Human Services's Departmental Appeals Board, 2007.	May 2008
	Centers for Medicare & Medicaid Services (CMS) Regulation	

14	HHS Office of Inspector General report, "Nursing Home Enforcement: Collection of Civil Money Penalties." (Executive Summary Only)	July 2005
15	HHS Office of Inspector General report, "Nursing Home Enforcement: The Use of Civil Money Penalties." (Executive Summary Only)	April 2005
16	HHS Office of Inspector General report, "Provider Enrollment, Chain and Ownership System: Early Implementation Challenges." (Executive Summary Only)	April 2007
17	CMS' Special Focus Facility Initiative	04/23/2008
18	CMS 2008 Action Plan for (Further Improvement of) Nursing Home Quality."	
	Haven Healthcare	
19	Hartford Courant article, by Lisa Chedekel, et al, re: "No Haven for the Elderly."	11/18/2007
20	Hartford Courant article, by Lisa Chedekel, re: "State Soft on Nursing Levels."	11/19/2007
21	Harford Courant article, by Lisa Chedekel, et al, re: "Haven Debt Woes."	11/20/2007
22	Hartford Courant article, by Lisa Chedekel, re: "Haven Alarm Raised in '06."	12/18/2007
23	Harford Courant article, by Lisa Chedekel, re: "Michigan Company May Buy Haven Nursing Homes."	05/01/2008
24	Haven Nursing Facilities and Affiliated Entities Organizational Chart.	11/11/2007
25	United States Bankruptcy Court documents, re: Haven Eldercare, LLC.	11/20/2007
26	Hartford Courant photo, subject: Oscar and Susana Aceituno.	11/01/2007
27	Hartford Courant article, by Lisa Chedekel, re: "Legislature Left Nursing-Home Reforms on Table."	05/09/2008
28	Ray Termini Resume	

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:

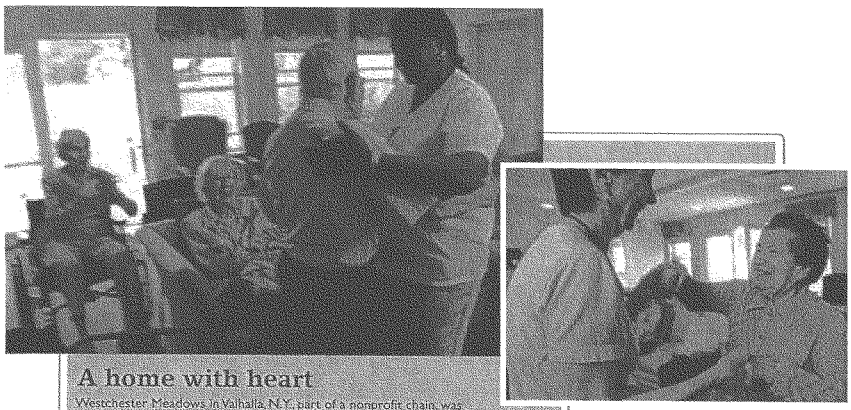
- Not-for-profit homes are more likely to provide good care than for-profits, based on our analysis of inspection surveys, staffing, and quality indicators.
- The same analysis shows that independently run homes are more likely to provide good care than chains.
- Through its influence in politics, the 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

Westchester Meadows in Valhalla, N.Y., part of a nonprofit chain, was among the homes in the best 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.

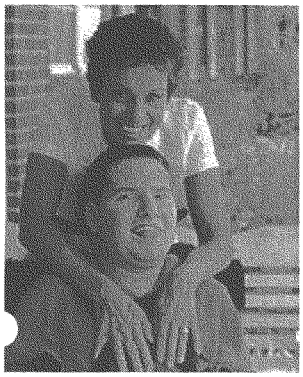
The most common remedy for violations is a "plan of correction." The nursing home acknowledges there is a problem and promises to fix it within a specified period. Often the problem is corrected but soon resurfaces, a phenomenon regulators call yo-yo compliance.

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.

Nursing Home Care Quality

Twenty Years After The Omnibus Budget Reconciliation Act of 1987

Prepared by

Joshua M. Wiener, Ph.D.

Marc P. Freiman, Ph.D.

David Brown, M.A.

RTI International

Nursing Home Quality

Twenty Years After The Omnibus Budget Reconciliation Act of 1987

December 2007

Prepared for

The Henry J. Kaiser Family Foundation

Prepared by

Joshua M. Wiener, Ph.D.
Marc P. Freiman, Ph.D.
David Brown, M.A.
RTI International

This report was commissioned by the Kaiser Family Foundation. Conclusions or opinions expressed in this report are those of the authors and do not necessarily reflect the views of the Kaiser Family Foundation.

CONTENTS

Executive Summary I
Introduction 1
Background 3
The State of Quality Assurance in Nursing Homes Before OBRA 87 3
How OBRA 87 Came to Be Enacted 4
Major Provisions of OBRA 87 5
The Impact of OBRA 87 on Nursing Home Care 9
Trends in Survey Deficiencies 10
Assessments and the Minimum Data Set 11
Administration on Aging's Long-Term Care Ombudsman's Data 14
Physical and Chemical Restraints 15
Nursing Home Staffing 16
Inspection and Enforcement 21
New Directions in Long-Term Care 24
Reforming Medicare and Medicaid Reimbursement 24
Changing Organizational Culture 27
Providing More Information to Consumers 28
Providing More Home and Community-Based Services 30
Future Outlook 33
References 37
Appendix 46

List of Exhibits

Exhibit 1: Spending for Nursing Home Care, 2005 1
Exhibit 2: Average Number of Deficiencies per Certified Nursing Facility 10
Exhibit 3: Percentage of Certified Nursing Facilities with Deficiencies 11
Exhibit 4: Percent of Certified Facilities Cited for Deficiencies in 2006 11
Exhibit 5: Percent of Certified Nursing Facilities Receiving a Deficiency for Actual Harm or Jeopardy of Residents 12
Exhibit 6: Trends in Certified Nursing Facility Chronic Care Quality Measures 13
Exhibit 7: Trends in Certified Nursing Facility Post-Acute Care Quality Measures 13
Exhibit 8: Certified Nursing Facility Complaint Summary for FY2000–2005 14
Exhibit 9: Percent of Certified Nursing Facilities with Deficiencies in Physical Restraints, 1994–2006 15
Exhibit 10: Nursing Staff Full Time Equivalents per 100 Certified Nursing Facility Residents 17
Exhibit 11: Nursing Hours per Resident Day in All Certified Nursing Facilities 17

EXECUTIVE SUMMARY

The year 2007 marks the 20th anniversary of the enactment of the Nursing Home Reform Act as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), landmark legislation that substantially changed the nursing home quality assurance system by changing the focus of regulation, establishing new standards, and revamping the inspection and enforcement process. In the years leading up to the passage of the nursing home reform amendments, there was widespread concern about poor quality of care and ineffective regulation of nursing facilities. Scandals and exposés about poor-quality care, abuse, and fraud in nursing homes were common. The passage of this landmark legislation was a rare example of the coming together of all interested parties—consumer advocates, industry, government, and researchers—to improve public policy and was an important example of a government-sponsored commission having a major impact on public policy.

This paper examines progress and problems in quality assurance in nursing homes over the last 20 years and considers the implications for the future quality of long-term care. In 2007, approximately 1.4 million people live in nearly 16,000 nursing homes nationwide. With roughly half of all nursing home care funded by Medicaid, and another 16 percent funded by Medicare, federal and state governments have a substantial interest in the care provided, particularly given the significant frailties of this population. More than two-thirds of elderly nursing home residents have multiple chronic conditions, 6 in 10 have multiple mental/cognitive diagnoses, and more than half are aged 85 and older.

OBRA 87 changed the previous federal system of regulating nursing homes in three important ways. First, OBRA 87 established new, higher standards that were much more resident focused than previous standards. The law established a number of quality-of-life rights, including freedom from abuse, mistreatment, and neglect and the ability to voice grievances without fear of discrimination or reprisal. Physical restraints, which had been quite common, were allowed under only very narrow circumstances and strict requirements were established limiting the amount of time that residents could be restrained. The law also upgraded staffing requirements for nursing homes, requiring facilities to have a registered nurse as director of nursing and licensed practical nurses on duty 24 hours a day, 7 days a week, and required a minimum of 75 hours of training for certified nursing assistants, who were also required to pass a competency test.

Second, OBRA 87 established an enforcement system for noncompliant nursing homes that incorporated a range of enforcement sanctions. States were required to conduct unannounced surveys, including resident interviews and direct observation of residents and their care, at irregular intervals at least once every 15 months, with the statewide average interval not to exceed 1 year. Noncompliant nursing homes were potentially subject to enforcement sanctions designed to match the severity of the nursing homes' deficiencies.

Third, OBRA 87 merged Medicare and Medicaid standards and survey and certification processes for nursing homes into a single system. This ended the confusion about the largely arbitrary and state-specific distinction between skilled nursing facilities and intermediate care facilities. The new standards were substantially higher than had existed for intermediate care facilities.

Over the past 20 years, nursing home care has changed, with some evidence of improvements over time. For example, the implementation of the Minimum Data Set (MDS) provides facilities with detailed and systematic information on the status of residents that can be used for care planning, to assess improvement and decline in resident status, and to identify quality-of-care problems. By 2007, fewer than 6 percent of long-stay nursing home residents had been restrained during the last 7 days. In terms of staffing, registered nurse staffing increased with the mandates of OBRA 87 and aides are now required to have at least a modest amount of training before starting to care for residents. And, the average number of deficiencies cited per facility has declined in recent years, although this measure may be an indicator of how vigorously the standards are being applied.

Yet challenges remain. More than 90 percent of all certified facilities were cited for one or more deficiencies in 2006, and nearly one-fifth of all certified facilities were cited for deficiencies that caused harm or immediate jeopardy to residents. Although there was an initial upgrading of the quality of care as a result of OBRA 87, improvements appear to have reached a plateau. Substantial proportions of nursing homes are still cited for inadequate care. Staffing levels have been relatively stable for many years, despite the increased acuity and disability of residents. The best available studies suggest that the vast majority of nursing homes are significantly understaffed.

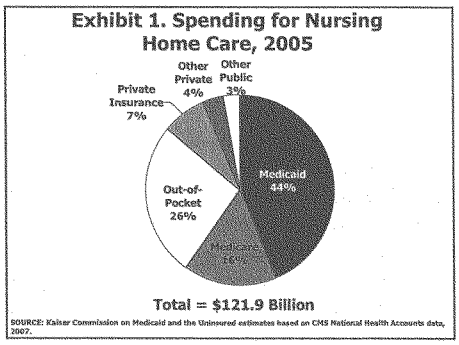
Looking to the future, there are several strategies that are receiving consideration for improving nursing home care that go beyond regulatory strategies. These approaches include reforming Medicaid and Medicare reimbursement, changing organizational culture, and providing more information to consumers. These options seek to change the organizational

incentives so that nursing homes will be motivated to improve quality of care and life. Another major direction in long-term care is the expansion of home and community-based services, both in the homes of consumers and in residential care facilities. Currently, relatively little is done to monitor quality of care in these noninstitutional settings.

In the 20 years since the passage of OBRA 87, substantial progress has been made in providing improved quality care to nursing home residents, yet significant problems remain. Many of the problems identified prior to the passage of OBRA 87 still persist. The 20th anniversary of the nursing home reform amendments provides an important opportunity to consider lessons learned, assess options for the future, and establish strategies for caring for an aging population in a range of long-term care settings.

INTRODUCTION

Nursing homes are an important component of long-term care for older people and younger adults with disabilities. In June 2007, there were 15,827 nursing homes in which 1,425,484 people resided (American Health Care Association, 2007a). Medicaid and Medicare are particularly important sources of funding for nursing homes, with three-quarters of residents dependent on one of the two programs, principally Medicaid, giving the federal government an especially large interest in the care provided. In 2005, Medicaid and Medicare, together, accounted for 60 percent of spending for nursing home care. Medicaid spent $53.6 billion on nursing home care and Medicare spent $19.5 billion, for a total of $73.1 billion (Kaiser Commission on Medicaid and Uninsured, 2007). Expenditures for nursing home care from all sources for 2005 are presented in **Exhibit 1**.



In order to receive Medicaid and Medicare reimbursement, nursing homes must be licensed by the state in which they are located and certified as meeting the federal quality standards for nursing homes. While the standards are federal, almost all of the actual inspections and most enforcement are conducted by state Departments of Health, giving states a major stake and responsibility in the quality assurance process. Given the financial dominance of Medicaid and Medicare, it is not surprising that federal quality assurance standards, mandated inspections, and enforcement processes dominate the formal quality assurance system for nursing homes.

Nursing homes today provide both post-acute care and services for longer-term residents. In 2004 the typical long-stay resident was over age 85 (53 percent), female (76 percent) and widowed (60 percent) (Kasper and O'Malley, 2007). While the vast majority of nursing home residents were over age 65, about 10 percent were under age 65 (Decker, 2005). More than two-thirds of elderly nursing home residents had multiple chronic conditions and another six in ten had multiple mental/cognitive diagnoses (Kasper and O'Malley, 2007).

Nursing homes are serving a sicker population than in the past. For example, between 1985 and 1999, the proportion of nursing home residents who did not require assistance to eat, bathe, dress, and walk declined (Decker, 2005). Among elderly nursing home residents in 2004, disease prevalence was higher and multiple physical and mental/cognitive conditions were more common than in 1999, although the percentage of residents with a diagnosis of dementia remained roughly constant at just under one-quarter (Kasper and O'Malley, 2007).

The year 2007 marks the 20th anniversary of the enactment of the Nursing Home Reform Act as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), which established the current federal framework for regulating nursing homes. This landmark legislation dramatically changed the quality assurance system for nursing homes by changing the focus of regulation, establishing new standards, and revamping the inspection and enforcement process. Although progress has been made, substantial problems remain with quality of care in nursing homes (Institute of Medicine, 2001; U.S. Government Accountability Office [GAO] 2005, 2007a, b). For example, the Administration on Aging's national ombudsman reporting system received more than 230,000 complaints in 2005 concerning nursing facility residents' quality of care, quality-of-life problems, or residents' rights (Administration on Aging, 2007).

This paper examines progress and problems in quality assurance in nursing homes over the last 20 years. The paper begins with a background section that reviews the problems that OBRA 87 was designed to address, briefly discusses the history that led to its passage, and describes the main elements of OBRA 87 as they relate to nursing home quality. The second section reviews trends in nursing home quality as evidenced by available reports of trends in citations for deficiencies, staffing, and quality indicators. It also analyzes the effect of the principal components of OBRA 87 and identifies areas of continuing problems. The third section identifies issues for quality assurance in long-term care for the future and some new strategies for improvement that have been proposed. The last section discusses the implications of the findings of the report for the future quality of long-term care.

BACKGROUND

The State of Quality Assurance in Nursing Homes Before OBRA 87

Concern about poor quality of care and ineffective regulation of nursing facilities dates back at least to the 1970s if not earlier (New York State Moreland Act Commission on Nursing Homes and Residential Facilities, 1975; U.S. Senate Special Committee on Aging, 1974; Wiener, 1981). Scandals and exposés about poor-quality care, abuse, and fraud in nursing homes were depressingly common.

In 1965 the legislation enacting the Medicaid and Medicare programs gave the U.S. Department of Health, Education, and Welfare the authority to set standards for participating nursing homes. However, the standards were weak and all but a few nursing facilities were able to meet the standards, despite reports of poor quality care. Federal legislation in 1967 and 1972 authorized the Department of Health, Education, and Welfare to develop and implement stricter standards. The 1967 legislation also authorized two categories of Medicaid nursing homes: skilled nursing facilities for residents requiring skilled nursing care and intermediate care facilities for residents requiring less nursing care and more personal care services. Prior to the enactment of OBRA 87, the system of federal regulations governing the certification of nursing homes under the Medicare and Medicaid programs had been essentially unchanged since the mid-1970s (Institute of Medicine, 1986).

The pre-OBRA 87 quality regulations focused on nursing homes' ability to provide care rather than the quality of care received by residents—in other words, structure rather than process and outcome (U.S. GAO, 1999). The standards primarily addressed such topics as the physical plant, the cleanliness of buildings, plumbing, food preparation equipment, broken windows, and lighting fixtures. Some measures were related directly to patient care, such as physical restraints, whether residents were properly exercised, and whether residents received proper grooming, but they were not the focus of the standards (U.S. GAO, 1987).

Management of the certification process under these standards was fragmented and quality assurance activities were limited. Although all surveys were conducted by state survey agencies, the Health Care Financing Administration, the predecessor to the Centers for Medicare & Medicaid Services (CMS), was responsible for enforcement and the final certification decision of nursing homes receiving Medicare payments, while states were responsible for the enforcement and the final certification decision of nursing homes receiving Medicaid (U.S. GAO, 1987). Surveys of nursing homes focused on whether there were written procedures in place—"paper compliance"—and could be conducted through a review of facility records

without observing residents (Hawes, 1997). Health Care Financing Administration oversight of the certification survey process by state agencies consisted of desk reviews of survey documents, visits to state agencies, and limited visits to selected facilities. The primary enforcement mechanism for state-certified Medicaid nursing homes was decertification for participation in Medicaid and Medicare, which was usually tantamount to closing the facility because of the high reliance on government revenues, and was seldom used. The General Accounting Office (1987) found widespread noncompliance with certification requirements. Many facilities were repeat offenders, and while they submitted plans of correction they never implemented them.

The regulatory process was further fragmented by differences in approach and resources committed to the nursing home certification process across states. For example, states were not consistent in making distinctions between the two types of nursing facilities: some states had almost no skilled nursing facilities; others had almost no intermediate care facilities (Institute of Medicine, 1986). Access to information about nursing facilities and residents also varied greatly among the states.

How OBRA 87 Came to Be Enacted

The roots of the passage of OBRA 87 can be traced to when Ronald Reagan became president in 1981. The Reagan Administration was philosophically skeptical of government regulation, believing that it placed unnecessary burdens on businesses for little societal gain. Very early on, the Administration focused on regulatory reform in the nursing home industry as the first of many industries for which it wished to change the regulations. Regulations that would have strengthened resident rights in nursing homes adopted in the final days of President Jimmy Carter's administration were withdrawn and the Health Care Financing Administration began a systematic examination of the Medicaid and Medicare nursing home quality standards, with an eye on eliminating unnecessary requirements. To many consumer advocates, these changes were tantamount to dismantling the existing quality assurance system. Leaks to the news media of proposed changes, especially to the *New York Times,* led to negative publicity and their disavowal by the White House and then-Secretary of Health, Education, and Welfare Richard Schwieker.

While efforts to revise nursing home quality standards ended, the Reagan Administration proposed new rules on Subpart S, which detailed the survey, certification, and enforcement process for nursing homes participating in Medicaid and Medicare. Among other provisions, these new rules allowed for self-surveys by providers under certain circumstances and "deemed" status, which would allow certification by a third-party organization to substitute for an

inspection by government agencies, both of which were strongly opposed by consumer advocates. Advocates believed that these provisions would have substantially weakened the inspection and enforcement process by relying on nursing homes to self-report their own problems and entrusting inspection and enforcement to a less rigorous process. In response, Congress twice passed legislation preventing these regulations from being implemented. After negotiations between the administration and Congress, a compromise was reached that would have the independent Institute of Medicine—part of the National Academy of Sciences—conduct a study of nursing home standards, inspections, and enforcement. It was hoped that by bringing in a neutral third party the impasse between the Administration and Congress would end.

The Institute of Medicine panel contained a broad range of providers, consumers, and researchers and was led by Sidney Katz, M.D., a prominent researcher on measuring disability. The report by the Institute of Medicine, *Improving the Quality of Care in Nursing Homes,* was issued in 1986, and unlike some Institute studies, this report contained dozens of detailed recommendations that could be translated into legislation.

Following the issuance of the report, Elma Holder and Barbara Frank of the National Citizens Coalition for Nursing Home Reform convened the Campaign for Quality Care, which included all of the major stakeholders on nursing home quality. Although there were issues of contention between consumer advocates and the nursing home industry (such as whether to impose minimum staffing ratios), the committee hammered out a compromise bill that was supported by the industry and consumer advocates. Hearings before Congress, which featured actor Kirk Douglas, the honorary chairperson of the group, galvanized the House and Senate, especially since the bill had exceptionally broad support. Because of the rules governing reconciliation bills that made it hard to amend the bill and to veto it, the placement of the nursing home quality initiative in an omnibus budget reconciliation bill further increased its likelihood of becoming law. The Omnibus Budget Reconciliation Act of 1987 overwhelmingly passed Congress and was signed by President Reagan.

Major Provisions of OBRA 87

OBRA 87 changed the previous federal system of regulating nursing in three ways (Hawes, 1996). First, the law established new, higher standards that were much more resident focused than previous standards. Second, the law established an enforcement system for noncompliant nursing homes that incorporated a range of successful state enforcement sanctions. These were designed to provide graduated sanctions that would allow the enforcement

mechanism to match the severity of nursing home deficiencies. Third, the law merged Medicaid and Medicare standards and survey and certification into essentially a single system.

Setting Higher Standards

The first major component of the OBRA 87 reforms was to establish higher standards, with an emphasis on the resident. The general standard of the law was to promote "maximum practicable functioning." Specifically, the law and regulations (42 CFR Part 483) established the following:

- Nursing facilities are responsible for assisting residents in the maintenance of activities of daily living, including the ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication (42 CFR Part 483.25a).
- Preadmission screening and annual resident reviews should be conducted for residents with mental illnesses and certain other chronic conditions to ensure that they are not inappropriately being held in nursing homes and that those appropriately placed in nursing homes receive appropriate services (42 CFR Part 483.112-116).
- Physical restraints are specifically prohibited for discipline or convenience, and specific indications are required for the use of antipsychotic medications to reduce their use as chemical restraints (42 CFR Part 483.13).
- A range of other support services should be provided or arranged, including social activities; medically related social services; dietary services; physician and emergency care services; and pharmacy, dental, and rehabilitation services such as physical, speech, and occupational therapies (42 CFR Part 483.15, .35-.60).
- That residents be assessed upon entry and periodically after that, and that the assessment be used to develop a written plan of care prepared and periodically reviewed and revised by a team including the attending physician and a registered nurse. The law specified the creation of a new, standardized, "reproducible," comprehensive functional assessment tool that would be used to assess all residents. This tool would generate a data set to be used for clinical assessment and individualized care planning for each resident. These data were also to be a resource for facilities to measure and improve their overall performance, and available for regulators to track resident outcomes (42 CFR Part 483.20).

The law and regulations also established a number of quality-of-life rights along with the standards on quality of care (42 CFR Part 483). These rights included the right

- to freedom from abuse, mistreatment, and neglect;
- to freedom from physical restraints;
- to privacy;
- to accommodation of medical, physical, psychological, and social needs;

- to participation in resident and family groups;
- to be treated with dignity;
- to exercise self-determination;
- to communicate freely;
- to participate in the review of one's care plan, and to be fully informed in advance about any changes in care, treatment, or change of status in the facility; and
- to voice grievances without discrimination or reprisal (42 CFR Part 483.10).

As a part of this emphasis on rights of residents against arbitrary actions by the nursing home administrator or other staff, OBRA 87 also included provisions giving residents more rights to communicate with regulators. The law specified that residents have access to a state long-term care ombudsman, established under the Older Americans Act. The law also guaranteed a resident the right to a personal attending physician. The law guaranteed that a resident would be transferred or discharged only for reasons of health, safety, welfare of the resident or other residents, nonpayment, or facility closure. In case of transfer or discharge, the nursing home was required to give notice and the resident had a right to appeal the decision.

OBRA 87 also revised and standardized the staffing requirements for nursing homes. Under the law, all nursing facilities were required to have a registered nurse as director of nursing, with licensed practical nurses on duty 24 hours a day, 7 days a week (Zhang and Grabowski, 2004). Nursing facilities were required to have a registered nurse on duty 8 hours a day, but this requirement was not linked to facility size (Harrington et al., 2000). A minimum of 75 hours of training was required for nursing aides, who were also required to pass a competency test. The law required "sufficient" staff and services to help residents attain or maintain the highest possible level of physical, mental, and psychosocial well-being, but no staffing ratios were established (Zhang and Grabowski, 2004). Nursing facilities were required to see that the medical care of each resident was supervised by a physician and that a physician was always available (42 CFR Part 483.40).

Revised Survey and Enforcement System

Under the law and regulations, states are required to conduct unannounced surveys, including resident interviews, at irregular intervals at least once every 15 months, with the statewide average interval not to exceed 1 year (42 CFR Part 483). These inspections also are to include interviews with family members and ombudsmen about residents' daily experiences. They also are to include direct observation of residents and their care. These surveys are to be conducted by a multidisciplinary team of trained professionals (42 CFR Part 483.305-325).

Noncompliant nursing homes are subject to enforcement sanctions designed to match the severity of the nursing homes' deficiencies. These sanctions are designed to reflect the circumstances of deficiencies and the actual or potential harm to residents. For some violations, nursing homes have the opportunity to correct the deficiency before remedies are imposed. The law provides the following sanctions:

- directed in-service training of staff,
- a directed plan of correction,
- state monitoring,
- civil monetary penalties,
- denial of payment for all new Medicaid or Medicare admissions,
- denial of payment for all Medicaid or Medicare patients,
- temporary management, and
- termination of the provider agreement (42 CFR Part 488.320).

Merger of Medicare and Medicaid Standards and Processes

OBRA 87 established a single set of higher requirements for skilled nursing and intermediate care facilities, other than facilities for the mentally retarded, and made survey and enforcement the same. This single set of standards greatly simplified the process and ended the confusion about the largely arbitrary and state-specific distinction between skilled nursing facilities and intermediate care facilities. The new standards were also substantially higher than had existed for intermediate care facilities, thus disproportionately affecting Medicaid-only facilities. These unified requirements included support for resident functioning, special screening and reviews for mentally and chronically ill residents, limits on physical and psychotropic restraints, and a range of support services.

This movement to a single set of requirements made it more efficient for the federal government to use the combined Medicaid and Medicare conditions of participation for payment as leverage to obtain higher performance. As preconditions for payment under both programs, nursing homes were required to meet these standards for all of their residents, including private pay residents.

THE IMPACT OF OBRA 87 ON NURSING HOME CARE

Over the last 20 years, nursing home care has changed a great deal. This section reviews changes using a variety of data sources. In discussing the quality of the experience of nursing home residents, the domains of quality are often divided into quality of care and quality of life. While related, these domains are analytically separate and address separate parts of the care experience.

In long-term care, a major quality focus is on health and safety, including potential markers of poor quality such as malnutrition, bedsores, uncontrolled pain, and excessive use of hypnotics and antipsychotic medications. For example, quality of care assessments include whether nursing homes assist residents with eating, whether there is adequate staffing to assist residents at mealtime, and whether residents maintain an appropriate weight. As the statistics presented below demonstrate, the vast majority of existing regulations and quality measures focus on quality of care.

In contrast, quality of life refers to much more intangible factors, such as autonomy, dignity, individuality, comfort, meaningful activity and relationships, a sense of security, and spiritual well-being (National Citizens' Coalition for Nursing Home Reform, 1985; Noelker and Harel, 2000). These factors are, by definition, subjective, but they are critical to living a good and meaningful life. To continue with the feeding example, quality of life refers to the tastiness of the food, the ability to choose meals that fit with personal preferences and ethnic heritage, the friendliness and patience of the staff helping with feeding, and the willingness of the staff to let residents feed themselves to the extent possible, even if it takes additional time.

Almost all of the available quantitative data on nursing homes are on the quality of care rather than the quality of life. Quantitative data on the quality of nursing home care are available from several sources, most importantly

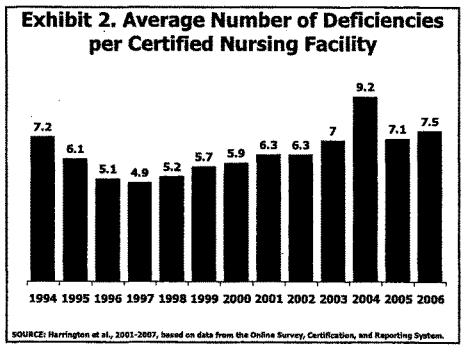
- nursing home survey data,
- quality indicators calculated from the Minimum Data Set (MDS), and
- complaints to state nursing home ombudsmen.

CMS compiles the results of inspections by nursing home surveyors to determine compliance with the requirements for participation in the Medicaid and Medicare programs and consolidates them into the Online Survey, Certification and Reporting system. Key data about all nursing home residents (including private pay residents) are also collected as part of the federally mandated MDS, which gathers functional and medical information on residents on a periodic

basis. MDS data are used to construct quantitative "quality indicators" (Zimmerman et al., 1995). CMS uses these quality indicators as part of the survey and certification process and makes 19 of them available to the public on its Nursing Home Compare website (http://www.medicare.gov/NHCompare; the indicators are defined in the **Appendix**). Finally, the Administration on Aging-funded Ombudsman Program receives and investigates complaints about nursing homes. The main advantage of these data is that they are an indication of quality as perceived by the consumer. Each set of data has its own strengths and weaknesses, making it difficult to draw definitive conclusions about the status of nursing home quality in the United States and their trends over time.

Trends in Survey Deficiencies

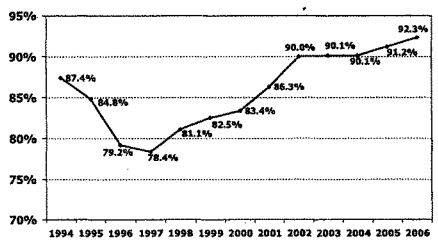
Researchers at the University of California, San Francisco, have tracked national trends in deficiencies of facilities cited by state surveyors from 1994 to 2006 (Harrington et al., 2007). While these data provide a valuable longitudinal view of the status of nursing homes by independent surveyors, variations—within states, across states, and across time—in how and whether surveyors cite facilities means that the data must be interpreted with caution. Thus, it is not clear whether the trends in the data are the result of changes in nursing homes or changes in the application of the surveys. (See below in the section on enforcement for a further discussion.) Comparable data are not available for the pre-OBRA 87 period.



Overall, the average number of deficiencies per certified nursing facility decreased from 7.2 in 1994 to 4.9 in 1997, followed by a gradual increase to 7.5 in 2006 (with a spike to 9.2 in 2004) (**Exhibit 2**). From another perspective, the proportion of facilities with no cited deficiencies rose from 12.6 percent in 1994 to 21.7 percent in 1997; since then the percentage of facilities with no deficiencies has fallen substantially, reaching 7.7 percent in 2006 (**Exhibit 3**).

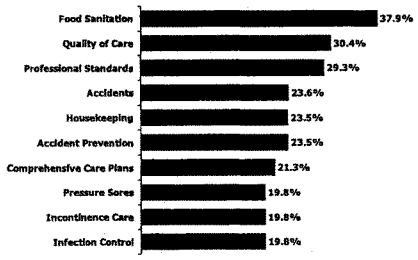
The 10 most commonly cited deficiencies during 2006 suggest that, for most categories, about one-fifth of facilities received citations, although not necessarily the same facilities (**Exhibit 4**). While the list includes housekeeping and food sanitation, which are not necessarily directly related to resident care, 23.6 percent of facilities were cited for accidents, 19.8 percent of facilities were cited for deficiencies related to pressure sores and related to incontinence care, and 30.4 percent of facilities were cited for quality-of-care deficiencies.

Exhibit 3. Percentage of Certified Nursing Facilities with Deficiencies



SOURCE: Harrington et al., 2001-2007, based on data from the Online Survey, Certification, and Reporting System.

Exhibit 4. Percent of Certified Nursing Facilities Cited for Deficiencies in 2006



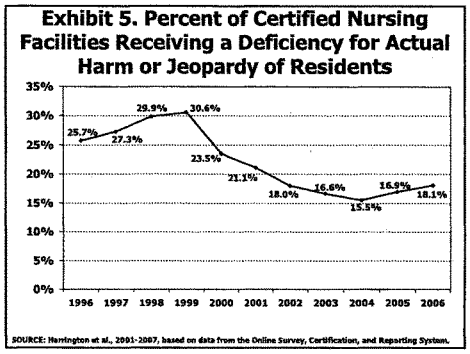
SOURCE: Harrington et al., 2001-2007, based on data from the Online Survey, Certification, and Reporting System.

Beginning in July 1995, surveyors also began to rate the scope and severity of each deficiency. The percentage of facilities with deficiencies that caused harm or immediate jeopardy to residents rose from 25.7 percent in 1996 to 30.6 percent in 1999, before declining dramatically to 15.5 percent in 2004; the percentage of facilities with such deficiencies rose slightly to 18.1 percent in 2006 (**Exhibit 5**). Thus, these serious deficiencies affect almost one-fifth of all nursing homes. Comparable data are not available for earlier periods.

Assessments and the Minimum Data Set

The provision of OBRA 87 that has likely had the greatest impact on the day-to-day processes of nursing home care is the requirement for an assessment using a federally mandated form. Prior to

OBRA 87, studies found that assessment information was often inaccurate, incomplete, and unrelated to a care plan (Hawes, 1997).



OBRA 87 requires nursing homes to use a uniform Resident Assessment Instrument for all nursing home residents. The Resident Assessment Instrument provides a comprehensive, structured approach to determining a resident's need for care and treatment in preparing a plan of care. The instrument must be administered on admission to the nursing home, at least annually thereafter, and when any significant change in status occurs. The Resident Assessment Instrument includes a standardized set of data elements (the Minimum Data Set) on the resident's medical, physical, functional, and affective status, and more detailed Resident Assessment Protocols that represent common problem areas or risk factors for nursing home residents. Although the studies did not rely on a random sample of facilities and the test environment did not always match that for routine use of the instrument, the reliability and validity of the MDS has been found to be good (Institute of Medicine, 2001). These data are now routinely reported to CMS and provide a wealth of information about nursing home residents.

In addition, the MDS has been used to develop quality indicators for nursing homes (Zimmerman et al., 1995). Compared to inspection reports, they focus on resident "outcomes" rather than the structural characteristics of the nursing home or the processes by which the nursing home provides care. Thus, these measures leave how to accomplish the outcomes to the individual nursing home, avoiding micromanagement.

The MDS-derived quality indicators are divided into those that apply to people who have long-term or chronic care needs and those that apply to people who use nursing homes only for short stays. Importantly, there is no summary or overall rating or ranking of facilities. These measures appear to be correlated with other measures of quality. For example, Carter and Porell (2006) found that variations in hospitalization risk among nursing home residents were explained in part by facility performance on quality indicators.

As shown in **Exhibits 6 and 7**, with few exceptions the quality indicators have been quite stable between 2002 and 2007. Among chronic care residents, the exceptions are that there has been:

Exhibit 6. Trends in Certified Nursing Facility Chronic Care Quality Measures

	2002	2003	2004	2005	2006	2007
Physical Condition and Depression-Related Measures						
Depression	-	-	15.3%	15.0%	14.7%	14.4%
High-Risk Pressure Ulcer	-	-	14.3%	14.0%	13.1%	12.8%
Physical Restraints	9.7%	8.6%	7.6%	7.1%	6.4%	5.6%
Pain	10.7%	7.6%	6.3%	6.4%	5.2%	4.5%
Low-Risk Pressure Ulcer	-	-	2.8%	2.7%	2.5%	2.3%
Physical Functioning and Weight Loss-Related Measures						
ADL	15.4%	16.1%	16.2%	16.6%	16.6%	16.1%
Mobility	-	-	13.3%	13.9%	13.6%	13.0%
Weight Loss	-	-	-	9.6%	9.0%	9.1%
Bedfast	-	-	4.4%	4.4%	4.3%	4.4%
Urinary System-Related Measures						
Incontinence	-	-	46.5%	47.5%	47.8%	48.8%
Urinary Tract Infections	-	-	8.3%	8.6%	8.7%	8.8%
Catheter	-	-	6.1%	6.3%	6.0%	5.9%
Vaccinations						
Influenza Vaccination	-	-	-	-	87.0%	87.0%
Pneumococcal Vaccination	-	-	-	-	77.1%	81.1%

Source: American Health Care Association, 2007a. Based on CMS Nursing Home Compare data. Figures are for the first quarter of 2003-2007 and the second quarter of 2002 (first quarter figures were not available), and the 4th quarter of 2004 for Vaccinations (where first quarter figures were not available).

- a decline in physical restraints from 9.7 percent in 2002 to 5.6 percent in 2007;
- a decline in pain, from 10.7 percent in 2002 to 4.5 percent in 2007 (and, among post-acute care residents, a decline in pain from 25.4 percent in 2002 to 20.7 percent in 2007); and
- an increase in residents receiving the pneumoccal vaccine, from 77.1 percent in 2006 to 81.1 percent in 2007.

Exhibit 7. Trends in Certified Nursing Facility Post-Acute Care Quality Measures

	2002	2003	2004	2005	2006	2007
Post-Acute Care Quality Measures						
Pain	25.4%	22.9%	22.0%	22.4%	21.7%	20.7%
Pressure Ulcer	-	-	20.7%	19.9%	18.3%	17.5%
Delirium	3.7%	3.0%	3.2%	2.9%	2.5%	2.1%
Influenza Vaccination	-	-	-	-	73.3%	73.2%
Pneumococcal Vaccination	-	-	-	-	68.8%	73.7%

Source: American Health Care Association, 2007a. Based on CMS Nursing Home Compare data. Figures are for the first quarter of 2003-2007 and the second quarter of 2002 (first quarter figures were not available), and the 4th quarter of 2004 for Vaccinations (where first quarter figures were not available).

Several concerns have been voiced about the use of MDS data for quality assurance purposes. First, some nursing homes may do well according to some indicators and poorly according to others, making summarizing the overall performance of a facility into a single score problematic, which limits their utility for consumers (Arling et al., 2005). Second, the relatively small size of most nursing homes and the modest prevalence of the measured quality problems create difficult statistical issues in determining which facilities are providing poor quality of care. For example, some of the more serious quality indicators, such as decubitus ulcers, do not involve many residents, even in poor facilities. Given the relatively small number of residents in nursing homes (the average facility has about 90 residents), random variation in the prevalence of decubitus ulcers may be substantial, thus making it difficult to distinguish good from fair or poor facilities. Third, risk adjustment is

statistically complicated and open to methodological challenge. In the end, facilities can only be held accountable for the care they provide, not their outcomes.

Although designed initially for care planning and for providing the data for quality indicators, use of the MDS has expanded to provide the basis for categorizing nursing home residents into Resource Utilization Groups, which is the casemix adjustment system used for Medicare prospective payment for skilled nursing facilities. The Resource Utilization Groups classification system is also used by many state Medicaid prospective payment systems.

Although the multiple uses of the MDS reflect positively on the versatility of the information collected, the fact that it is used for payment and regulatory purposes also raises questions about the accuracy of the data. A key issue is that facility staff fill out the MDS largely unsupervised by surveyors and rarely is the accuracy of the assessments checked. One factor that may improve the accuracy of the data is that the incentives go in the opposite direction for reimbursement and quality measurement. On the one hand, in order to maximize Medicare and Medicaid reimbursement, providers have a strong incentive to make residents look as disabled as possible, at least initially. On the other hand, providers have strong incentives not to report deterioration in the status of residents that could trigger investigation by state surveyors. In addition, different processes of data collection across facilities may produce different results (Harrington et al., 2003b).

Administration on Aging's Long-Term Care Ombudsman's Data

The Administration on Aging's Ombudsman Program investigates complaints about nursing homes. As shown in **Exhibit 8**, the total number of complaints about nursing homes has increased significantly from 186,234 in 2000 to 241,684 in 2005 (Administration on Aging, 2007). These complaints represent judgments about quality of care and life from the perspective of nursing home residents and their families.

Exhibit 8. Certified Nursing Facility Complaint Summary for FY2000-2005

	Total Complaints	Type of Complaints				
Year	Nursing Facilities	Residents' Rights	Resident Care	Quality of Life	Administration	Not Against Facility
2005	241,684	68,587	78,198	60,936	21,149	12,814
2004	227,721	63,689	75,481	53,112	20,642	14,797
2003	226,376	69,912	73,756	47,249	21,362	14,097
2002	208,762	65,889	66,501	41,423	22,119	12,830
2001	209,663	65,372	67,483	41,757	22,718	12,333
2000	186,234	56,829	60,785	36,326	20,791	11,503

Source: U.S. Administration on Aging.

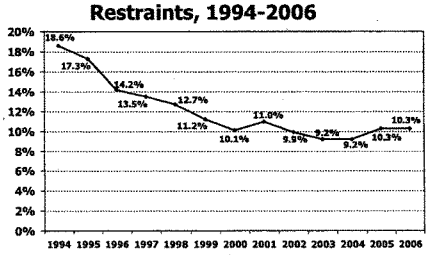
Physical and Chemical Restraints

Many observers believe that one of the biggest improvements in nursing home care since the passage of OBRA 87 is the reduction in the use of physical restraints in nursing homes (Institute of Medicine, 2001). Physical restraints are mechanical devices, materials, or equipment that restrict freedom of movement or normal access to one's body. Aside from the limitation of one's freedom and the implied assault on one's dignity, restraints can decrease muscle tone and increase the likelihood of incontinence, pressure sores, depression, and other problems. In the late 1980s, the prevalence of physical restraint use was estimated to be as high as 41 percent, with wide variability across facilities (Strumpf and Tomes, 1993).

OBRA 87 strongly discourages the use of restraints and prohibits nursing homes from using restraints unless they are medically indicated and ordered by a physician. Under OBRA 87, residents have the right to be free from any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat residents' medical symptoms. Nursing home residents have the right to refuse treatment, including the use of restraints. Importantly, OBRA 87 requires that residents cannot be kept in restraints indefinitely; residents must be released from restraints and exercised at least every 2 hours.

Studies conducted following the implementation of OBRA 87 found a reduction in the use of restraints. In one set of studies, use of physical restraints in 268 facilities in 10 cities dropped from 38 percent prior to the implementation of OBRA 87 to 28 percent following the implementation of OBRA 87 (Hawes et al., 1997; Phillips et al., 1996). Other studies have also found declines in the use of restraints (Capezuti et al., 1996; Castle and Mor, 1998; Ejaz et al., 1994; Graber and Sloane, 1995; Sundel et al., 1994). As shown in **Exhibit 9**, the percentage of facilities cited for improper use of restraints declined significantly through the mid-1990s and then leveled off between 2000 and 2006 (Harrington et al., 2007).

Exhibit 9. Percent of Certified Nursing Facilities with Deficiencies in Physical Restraints, 1994-2006



SOURCE: Harrington et al., 2001-2007, based on data from the Online Survey, Certification, and Reporting System.

Nursing Home Staffing

It is often asserted that the quality of care in nursing homes is impaired because staffing is inadequate, staff are insufficiently trained, and turnover is high, especially for certified nurse assistants (Decker et al., 2003; Stone and Wiener, 2001). Inadequate staffing is one of the most common complaints about nursing home care.

Low wages and lack of benefits along with difficult working conditions make recruitment and retention of nursing aides difficult (Stone and Wiener, 2001). Staff also account for the great bulk of nursing home costs, potentially creating a conflict with the incentives of prospective payment systems to keep costs low. As a result, some providers may be understaffed and the constant turnover adversely affects the ability of staff to understand the needs and preferences of individual clients and to develop a personal rapport with them. Difficulty in recruiting aides is likely to worsen over time as the number of people needing long-term care increases more quickly than the working-age population. Long-term care workers, such as personal care attendants, certified nurse assistants, and home health aides, receive low wages and generally lack fringe benefits such as health insurance and pension plans (Cousineau et al., 2000; Crown et al., 1995; Yamada, 2002).

Staffing Levels

OBRA 87 requires minimum staffing levels for registered nurses and licensed practical nurses. Specifically, Medicare and Medicaid certified nursing homes are required to have a registered nurse as the director of nursing; a registered nurse on duty at least 8 hours a day, 7 days a week; and a licensed nurse (registered nurse or licensed practical nurse) on duty the rest of the time. OBRA 87 also includes general language to the effect that nursing homes are "to provide sufficient staff and services to attain or maintain the highest possible level of physical, mental, and psychosocial well-being of each resident"

Neither federal law nor regulation provides specific guidance as to what constitutes "sufficient" staffing. Neither the Institute of Medicine report (1986) nor the law establishes specific staffing ratios, which was a concession by consumer advocates to the industry, which feared the increased costs. Although these staffing standards are rather modest, research has indicated that OBRA 87 had a positive effect on the quality of care, including a component that operated through increased staffing (Zhang and Grabowski, 2004). Data from the National Nursing Home Survey suggest that the implementation of OBRA 87 was associated with a 25 percent increase in staffing between 1985 and 1995, but staffing has been fairly flat since then, despite the increase in the disability levels of nursing home residents, discussed earlier

(**Exhibit 10**). Total staffing per 100 residents increased from 47.3 full-time equivalents in 1985 to 59.2 full-time equivalents in 1995.

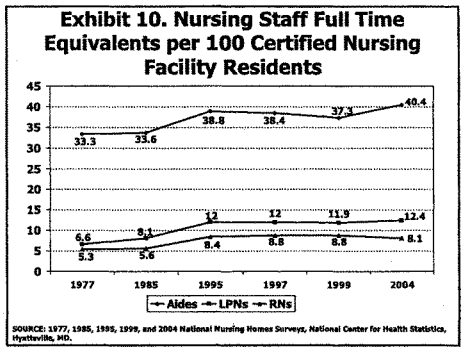
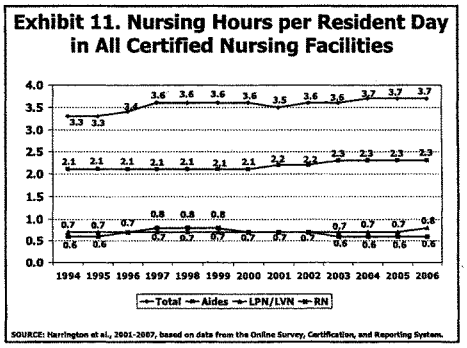


Exhibit 11 presents staffing levels in hours per resident day for registered nurses (RNs), licensed practical (or vocational) nurses (LPNs), and nursing assistants, as reported by facilities for a 2-week period prior to when the most current state survey was conducted (Harrington et al., 2007). The staffing data report payroll hours and are not a direct measure of the hours of care delivered directly to residents.

Total nursing hours per resident day increased minimally from 3.3 to 3.6 hours over the 1994–2003 period. Since then, total hours per resident day have increased very slightly to 3.7. Thus, staffing levels have been flat for at least a decade, despite an increase in the disability levels of nursing home residents discussed earlier. Registered nurse staffing hours per resident declined by 25 percent since 1999 (Harrington et al., 2007). More recently, concern has developed over the effect of ownership by private equity firms and its effects on staffing levels. A recent investigative report found that staffing was reduced at 60 percent of nursing homes bought by large private equity groups from 2000 to 2006 (Duhigg, 2007).



It is important to note that staffing ratios vary widely across facilities. For example, in 1998 the median facility provided 3.21 hours per resident day of nursing time, but the 10th

percentile facility provided only 2.46 hours per day and the 90th percentile facility provided 4.66 hours per day (Harrington and Carillo, 2000).

While staffing ratios provide a first approximation of the amount of resources available to care for nursing home residents, these ratios are not perfect:

- There is no "risk adjustment" to these staffing levels to account for the level of care needed by the residents of a facility.
- The staffing information may be either inaccurate or out of date. For example, it is widely believed that many nursing homes increase staffing during the period when they expect to be inspected.
- The staffing data include nursing staff who have administrative as well as direct care responsibilities. Thus, the number of staff available to actually provide care is likely to be smaller than the numbers would indicate.

A number of efforts have analyzed the relationships between staffing and the quality of care and the possibility of establishing additional staffing ratio requirements. In 2001, CMS reported to Congress on the results of research performed under contract by Abt Associates. The objectives of the research, using data from a representative sample of 10 states including over 5,000 facilities, was to identify staffing thresholds below which quality of care was compromised and above which there was no further benefit of additional staffing with respect to quality. The project found that there were incremental benefits from increased nurse staffing until a threshold was reached, at which point there were no further benefits with respect to quality. Depending on the nursing home population, these thresholds range between 2.4 and 2.8 hours per resident day for nurse aides, 1.15–1.30 hours per resident day for licensed staff (RNs and LPNs combined), and 0.55–0.75 hours per resident day for RNs, respectively. The report noted that if these maximum total effect thresholds were implemented as requirements, 97 percent of all nursing homes would fail to meet one or more of these standards. The report to Congress (CMS, 2002) found "strong and compelling" statistical evidence that nursing homes with a low ratio of nursing personnel to patients were more likely to provide substandard care, and the study authors recommended a *minimum* staffing ratio of 4.1 hours of care per resident day, about 10 percent higher than *average* current staff levels.

The report also stated that existing nurse staffing data are not sufficiently accurate for determining compliance with any nurse staffing requirements that might be implemented, or for consumer information. The report stated that it appears feasible to replace the current reporting requirement with electronic submission of a limited set of staffing variables derived from payroll records and invoices from contract agencies, and the Department of Health and Human Services

recommended that there be a new provider requirement of electronic submission of staffing data based on payroll data and invoices from contract agencies.

A number of other studies have found a positive association between nurse staffing levels (especially for registered nurses) and the processes and outcomes of care in nursing homes (Institute of Medicine, 1996, 2001). For example, Harrington et al. (2000) showed that higher nurse staffing hours were associated with fewer nursing home deficiencies. And the Government Accountability Office found that the quality of care in nursing homes is related more to staffing than spending (U.S. GAO, 2002).

Many specific reports of poor-quality care (e.g., rushed feeding and not answering call bells) appear to be linked to inadequate staffing levels. In a review of the literature, Bostick and colleagues (2006) concluded that there is an association between higher total staffing levels (especially licensed staff) and improved quality of care, and a relationship between high turnover and poor resident outcomes.

As a result of these numerous findings, many clinicians, researchers, and consumer advocates have called for higher, more specific standards than those instituted by OBRA 87. The Institute of Medicine (2001) recommended that CMS develop minimum staffing levels for direct care based on casemix-adjusted standards. An Institute of Medicine (2003) report on *Keeping Patients Safe: Transforming the Work Environment of Nurses* recommended that CMS adopt the minimum staffing levels from the Abt study for all nursing homes, along with 24-hour registered nurse coverage. Specific staffing standards have also been proposed by the National Citizen's Coalition for Nursing Home Reform and a panel of experts led by Charlene Harrington, a nursing home expert at the University of California–San Francisco, which has recommended minimum staffing at the 80th to 90th percentile of current staffing in nursing facilities (Institute of Medicine, 2001).

In the absence of such federal standards, some states have instituted additional staffing requirements. In one study, 15 states had higher registered nurse standards and 25 had higher licensed nursing standards. Eight states required a registered nurse on duty 24 hours per day for facilities with 100 or more residents. Thirty-three states required minimum staffing for nursing assistants (Harrington and Millman, 2001).

As was true in 1987, the nursing home industry and many government officials oppose the imposition of higher and more specific staffing requirements, primarily due to cost concerns. They argue that the additional costs could be significant depending on the minimum staffing

level established. A preliminary analysis by CMS's Office of the Actuary estimated that increasing nursing home staffing to the recommended 4.1 hours per day per nursing home resident would increase total nursing home costs by $7.6 billion, or 8.4 percent, in 2001 (CMS, 2001). Medicaid would incur perhaps two-thirds of these costs. Additionally, how staff are organized, supervised, and motivated is at least as important as the number of workers. Merely "throwing bodies" into a poorly run facility, they contend, will not improve quality of care. Further, the shortage of staff to work in long-term care makes higher staffing levels unrealistic. Recruiting and retaining workers is difficult (Decker et al., 2003). Thus, even with the best of intentions, it may be difficult to increase staffing levels.

Staff Training

OBRA 87 requires nursing assistants to receive a minimum of 75 hours of entry-level training, to participate in 12 hours of in-service training per year, and to pass a competency exam within 4 months of employment. OBRA 87 is silent on training requirements for other types of nursing home personnel. Yet one possible reason for poor quality in long-term care is that staff are not adequately trained. Especially with the increased acuity of nursing home residents and the greater complexity of care provided today, one strategy to improve quality of care is to significantly increase training requirements for all types of long-term care staff.

As nominal as the training requirements are for nurse assistants, they exceed what most other low-paid jobs require and may deter some people from working in the industry. On the other hand, the minimal training means that there is no career ladder for this type of work; it is the classic "dead-end job." There are three major issues involving staff training requirements:

- Although there is a logic to formal minimum training requirements, little research has been done to determine what those levels should be and what impact increased training has on quality of care.
- Training is not free. The costs of higher standards must be borne by workers, facilities, or the government.
- Higher training requirements may exacerbate staffing shortages by creating barriers to entry to working in long-term care. Despite this concern, 26 states require more than 75 hours of initial training and 13 of these require more than 100 hours (U.S. Department of Health and Human Services, Office of the Inspector General, 2002).

Inspection and Enforcement

Nursing facilities cannot operate unless they are licensed by the state in which they are located, and they cannot receive Medicare and Medicaid funding unless they are certified as meeting federal quality standards. The Institute of Medicine (1986) report noted "serious, even

shocking, inadequacies" in the enforcement of then-current nursing home regulations. It identified "large numbers of marginal or substandard nursing homes that are chronically out of compliance when surveyed...[and that] temporarily correct their deficiency....and then quickly lapse into noncompliance until the next survey" (p. 146).

Survey and Certification

CMS relies on the states to administer the regulatory process; CMS's regional offices oversee and monitor the state activities. CMS establishes specific protocols for state survey teams—generally consisting of registered nurses, social workers, dieticians, and other specialists—to use in conducting surveys. To monitor state compliance with federal rules, CMS performs federal comparative surveys in order to gauge the performance of the state survey systems. These procedures are intended to make on-site surveys thorough and consistent across states.

Although CMS has made a number of improvements in its survey and certification process, several problems have been identified:

- The U.S. Government Accountability Office (2005, 2007a,b) found inconsistency in how states conduct surveys. For example, Maryland identified actual harm and immediate jeopardy deficiencies in about 8 percent of the state's nursing homes, while Connecticut found such deficiencies in approximately 51 percent of its facilities. Although possible, it seems unlikely that quality of care actually varies that much across states (U.S. GAO, 2007b). Comparing regular survey teams with other teams that surveyed simultaneously within a state, Lee and colleagues (2006) concluded that the survey process was reliable when assessing aggregate results, but only moderately reliable when examining individual citations.
- Although the understatement of serious deficiencies identified by state surveyors as measured by repeat federal surveys has declined, it continues to be a serious issue, one that has persisted for many years (U.S. GAO, 1987, 2000, 2003, 2007b). In fiscal year 2006, 28 percent of federal comparative surveys found serious deficiencies that were not identified in state surveys (U.S. GAO, 2007b).
- State budget problems have caused hiring freezes and resistance to increasing staff in survey agencies (Scully, 2003); federal spending for survey and certification totaled $258 million in FY2006 and has been relatively flat for a number of years (U.S. Department of Health and Human Services, 2007). Survey and certification expenses are predominantly funded at the federal level, with the federal government funding 100 percent of the costs associated with certifying that nursing homes meet Medicare requirements and 75 percent of the costs associated with Medicaid standards (U.S. GAO, 2005). The states are responsible for the remaining 25 percent of the Medicaid portion of these surveys. Advocates for more aggressive regulation argue that additional funding would provide the resources needed to more actively monitor and enforce federal regulations. Studies have found that states that take more enforcement

actions and issue more civil money penalties are those that have higher state survey agency budgets from CMS (Tsoukalas et al., 2006; Walshe and Harrington, 2002).

- State survey agencies report that it is difficult to recruit and retain surveyors because of low salaries (U.S. GAO, 2005). Moreover, the long training period makes it difficult for states to replace surveyors when they leave or to increase the overall number of surveyors.

Enforcement

Regulations implementing the enforcement provisions of OBRA 87 did not take effect until 1995, 8 years after the passage of the law, in large part because of extended negotiations with the nursing home industry. The ultimate sanction is to decertify a facility from participation in Medicare and Medicaid, but OBRA 87 expanded the range of sanctions available to government regulators, adding civil money penalties, the ability to require staff training, and denial of payment for new admissions. Key steps taken by CMS to improve the enforcement process include revising the survey methodology, issuing additional guidance to strengthen complaint investigations, implementing quicker sanctions for homes cited for repeat serious violations, and strengthening oversight by conducting assessments of state survey activities (U.S. GAO, 2005).

There is substantial evidence of the inadequacies of current enforcement efforts:

- Historically, serious complaints by residents, members, or staff alleging harm to residents remained uninvestigated for weeks or months, and delays in the reporting of abuse allegations compromised the quality of available evidence, hindering investigations (U.S. GAO, 2005). More recently, CMS has focused attention on this issue (U.S. GAO, 2007b).
- When serious deficiencies were identified, federal and state enforcement policies did not ensure that they were addressed and remained corrected. To help address this, CMS established the Special Focus Program to identify and give special attention to facilities with a history of providing poor quality care. In an analysis of homes with serious quality problems in four states, the Government Accountability Office (2007) found that half of the facilities were out of compliance on subsequent surveys.
- Nursing homes with serious quality problems continued to cycle in and out of compliance, causing harm to residents (U.S. GAO, 1987, 2000, 2003, 2007a,b). In its reports, the Government Accountability Office recommended 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.
- The number of facilities receiving sanctions is low. Few nursing homes are decertified from the Medicare and Medicaid programs (U.S. GAO, 2007a,b). Moreover, few civil money penalties, holds on admission, and temporary management/receiverships are issued for serious violations of federal regulations (Harrington and Carrillo, 1999;

Harrington et al., 2004; Hawes, 2002; Tsoukalas et al., 2006). In 2004, 41 states collected 3,057 civil money penalties worth $21 million, but civil money penalties were given for only 2 percent of deficiencies issued (Tsoukalas et al., 2006). When a sanction such as denial of civil money penalties is imposed, there is a significant time lag between when the deficiency citation occurs and the effective date of the sanction (U.S. GAO, 2007a). One estimate is that for appealed cases, it takes 420 days to collect civil money penalties, providing facilities with a substantial period of time before payment (U.S. Department of Health and Human Services, Office of the Inspector General, 2005).

Advocates of government regulation argue that enforcement remains too weak and that stronger regulation would greatly improve quality of care. Most recommendations by researchers (Institute of Medicine, 2001), consumer advocates, and the Government Accountability Office (2003, 2005, 2007) for strengthening the regulatory process involve more aggressive enforcement of existing regulations. This approach could be initiated by the federal government, but state governments could take the lead, if they so choose. For example, this could include the following:

- targeting chronically poor-performing facilities and working to change ownership or put them out of business;
- strengthening the severity rating of deficiencies to define more situations as serious;
- increasing training of surveyors;
- reducing the predictability of the timing of the survey;
- shortening the length of time for investigating complaints that allege actual harm to residents;
- imposing more fines and other penalties, especially for facilities that place residents in immediate jeopardy; and
- strengthening and making more consistent the federal oversight of state survey activities.

NEW DIRECTIONS IN LONG-TERM CARE

Looking to the future, there are several other strategies that are receiving consideration for improving nursing home care that go beyond regulatory strategies. These approaches include reforming Medicare and Medicaid reimbursement, changing organizational culture, and providing more information to consumers. These options seek to change the organizational incentives so that nursing homes will be motivated to improve quality of care and life. Another major direction in long-term care is the expansion of home and community-based services, both in the homes of consumers and in residential care facilities. Currently, little is done to monitor quality of care in these noninstitutional settings.

Reforming Medicare and Medicaid Reimbursement

Compared to acute care services, long-term care is much more heavily dependent on public sources of reimbursement (U.S. Congressional Budget Office, 2004). Thus, the reimbursement policies of Medicare and Medicaid are critical to the level of resources available to long-term care providers, and to the extent that more resources translate into better quality, public reimbursement is a key factor. In addition, the form and type of reimbursement can provide incentives or disincentives for high quality.

The Importance of Reimbursement Methodologies and Levels

Medicaid and Medicare long-term care reimbursement policies are particularly important as policy levers because federal and state policymakers have great control over both the level and methodology of payment. The federal government sets Medicare reimbursement policy and states have almost complete freedom in setting Medicaid long-term care payment rates (Wiener and Stevenson, 1998). Providers often argue for increased Medicare and Medicaid reimbursement rates as a way to improve quality of care, arguing that resources provided by public reimbursement are inadequate. BDO Seidman (2007), in a study for the American Health Care Association, estimated that unreimbursed Medicaid allowable costs for nursing homes were $4.4 billion in 2007. An important feature of the long-term care market is that private payment rates are almost always higher than Medicaid reimbursement levels.

Not only is the level of payment important, but so is the method of payment. Payment for a range of services under Medicare has shifted from retrospective, cost-basis reimbursement to prospective payment. Payment levels vary according to selected characteristics of the individual, and a few selected characteristics of the provider, but not according to the actual costs incurred by each provider for treating each individual. Medicare pays prospectively for skilled nursing facility and home health care, as do almost all Medicaid programs.

Since prospective payment systems typically allow providers to keep the difference between the payment rate and the cost of providing services, it may provide incentives for providers to reduce costs related to patient care, which may adversely affect quality. Several studies (Konetezka et al., 2004, 2006; White, 2005) found that the implementation of the Medicare prospective payment system combined with the budget reductions of the Balanced Budget Act of 1997 were associated with declines in various levels of staffing.

There are two additional issues with increasing Medicare and Medicaid reimbursement rates as a strategy of improving quality of care in long-term care: First, the relationship between reimbursement levels and quality of care is complex, and simply raising reimbursement rates may not have a large impact on quality of care in nursing homes. Although research in this area is limited, some older nursing home studies have found that higher reimbursement is associated with more staffing but have failed to find a significant relationship to other measures of quality (Cohen and Spector, 1996; Nyman, 1988). In contrast, more recent studies have found a relationship between costs and quality outcomes in nursing homes, although the effect size is relatively modest (Grabowski, 2004; Grabowski & Angelelli, 2004; Grabowski et al., 2004). That is, relatively large increases in reimbursement are associated with relatively modest improvements in quality of care.

Second, higher Medicare and Medicaid reimbursement levels add to public costs. Thus, the dilemma for policymakers is that a dollar's worth of increased reimbursement may not yield a dollar's worth of quality improvement. Higher rates are diluted in a number of ways—including higher administrative expenses, profits, and inefficiency—that do not improve resident outcomes.

Pay for Performance

Another approach to linking reimbursement and quality in health and long-term care is "pay for performance," the name given to integrating quality incentives directly into the payment mechanism. An ideal reimbursement system will incorporate both incentives to economize on costs and incentives to maintain and improve quality. This is the promise of pay for performance—combining prospective payment with incentive payments that vary according to measures of the quality of the care provided. An outcomes-based reimbursement demonstration implemented in 36 proprietary nursing facilities in the San Diego area from 1980 to 1983 found beneficial effects on access, quality, and cost of care (Norton, 1992; Weissert et al., 1983), but it took place over 25 years ago.

To explore this concept, CMS has started planning for a number of pay-for-performance initiatives (CMS, 2005). These demonstrations largely will focus on health care delivered under Medicare, but some will include persons dually eligible for Medicare and Medicaid (CMS, 2007). Some states, such as Minnesota, are also exploring ways to link Medicaid payments to quality (Kane et al., 2007).

CMS has funded the design of a pay-for-performance reimbursement system in anticipation of a multistate demonstration of a Medicare skilled nursing facility quality-based purchasing system. In one version, the proposed demonstration design (White et al., 2006) pay-for-performance system for skilled nursing facilities would have the following characteristics:

- Performance measures. The system should include four categories of performance measures: (1) nursing home staffing level and turnover, (2) rate of potentially avoidable hospitalizations, (3) MDS-based resident outcome measures, and (4) outcomes from state survey inspections.
- Linking nursing home performance to performance payments. Homes with overall performance scores that are in the top 20 percent of performance levels should qualify for a performance payment. Homes in the top 20 percent in terms of improvement should qualify for a performance payment in recognition of their better performance, so long as their performance is at least in the 40th percentile in the performance year. Under the demonstration no homes will face payment reductions as a result of poor performance.
- The size of the performance payment pool. The size of the payment pool should be based on whether the demonstration results in savings to the Medicare program. If there are no savings, then there would be no performance payments regardless of any quality improvements.

This reimbursement system design raises at least four issues with the pay-for-performance approach: First, there are substantial technical problems related to establishing unambiguous measures of "high" quality. There is a risk that facilities providing average or even low-quality care may qualify for financial incentives, sending the wrong or confusing message to providers. Second, quality incentive payments may "guild the lily" by providing additional funds to facilities that already are likely to be doing well financially because they may have a high percentage of private pay residents who pay charges greater than Medicaid. Thus, scarce public funds will go to providers that do not need any more resources. Third, and conversely, in CMS's demonstration design, facilities that are below average can still obtain incentive payments if they improve substantially, providing additional funds to facilities whose performance is below average. Finally, although CMS must operate under Office of Management and Budget constraints requiring that demonstrations be budget neutral, high-quality nursing home care may

or may not result in Medicare savings, making the awarding of quality incentives dependent on something other than the nursing home's performance.

Changing Organizational Culture

Some observers have argued that the quality problems in long-term care, especially nursing homes, are the result of an organizational culture that is too hierarchical, too medical, and too bureaucratic. In response, a number of new approaches to structuring the social, cultural, and physical environments of the facilities have developed. The so-called Eden Alternative is probably the best known of these innovations in the nursing home sector (Thomas, 1994). This approach emphasizes community by linking the facility to the outside world—plants and animals are allowed, children interact with residents, and aides are empowered as an essential part of the care team. Many of these models involve physically redesigning the facility, emphasizing small "neighborhood" communities, and changing staffing patterns to promote continuity of care. This approach has led to the Green House movement, a particular embodiment of culture change for nursing homes that involves small facilities that are very homelike and where certified nursing assistants are deeply involved in decision-making (Rabig et al., 2006). In a study of Green House nursing homes in Mississippi, Kane and colleagues (2007) found generally higher satisfaction and quality of life in Green House homes than in the comparison group. Denmark has reformed its nursing homes along these lines (Stuart and Weinrich, 2001).

These innovations are intuitively appealing and appear to address many of the quality-of-life problems in traditional nursing homes. Encouraging these new care models by publicizing them and by providing implementation grants from federal and state governments and foundations might improve quality of care and life. In addition, federal and state regulations that hinder demonstrations could be modified.

While intriguing, these innovative programs are relatively recent and rare. Several issues confront advocates of using these models for quality improvement: First, although there has been a lot of media coverage, these innovations have not yet been rigorously evaluated or replicated under varying leadership, ownership, and case mix circumstances. In particular, some of the most dramatic changes may be the result of charismatic leadership, which may not be replicable when implemented on a broader scale. Second, implementing some of these models can be difficult because they are inconsistent with existing regulations. For example, the presence of birds or animals may violate sanitation requirements in some states, and some of the staffing arrangements skirt the boundaries of regulatory acceptability. Given that a number of facilities have implemented these changes, however, these barriers do not appear to be insurmountable.

Third, as the population in nursing facilities becomes more disabled and involves higher levels of medical complexity, some of the more medical characteristics of nursing facilities may be more appropriate than they were in the past and may be compromised by these new approaches.

However, any strategies must recognize that the average nursing home resident currently has 3.96 problems with activities of daily living (American Health Care Association, 2007b) and that there are approximately 16,000 nursing facilities in the United States. These facts make it difficult to design initiatives that will result in radical cultural change beyond a handful of facilities. Especially from a policy perspective, it is not clear how to change the culture of a large number of nursing homes.

Providing More Information to Consumers

One increasingly prominent approach to improving quality of care is to provide more information to consumers, their families, providers, hospital discharge planners, and others about the quality of individual long-term care providers (Harrington et al., 2003b; Mukamel and Spector, 2003). The underlying assumption is that the lack of information on the quality of individual providers results in a market failure. The premise of this approach is that armed with more information about quality of care, consumers will choose high-quality providers and avoid poor-quality providers (Bishop, 1988). Thus, in theory, market competition for residents and clients would force poor-performing providers to improve their quality of care or lose business. Hospital discharge planners, case managers, and others involved in the placement process could also use the information to advise individuals needing services and their families, steering them to high-quality providers. Lastly, providers could use the information to identify areas for improvement.

CMS has embraced this approach as a key component of its quality improvement strategy for a number of providers, including nursing homes, home health agencies, and end-stage renal disease dialysis facilities. Since 1998, CMS has operated the Nursing Home Compare website, which provides a wide variety of quality-related information about individual nursing homes (CMS, 2004). This website has been popular, averaging approximately 100,000 visits per month (U.S. House of Representatives Committee on Government Reform, 2002). In addition, there are websites that report quality information on individual nursing homes in California, Florida, Iowa, Maryland, Ohio, and Virginia (Shugarman and Garland, 2006). While older persons currently take little advantage of online information, such information may play a greater role in the future —less than one-third (31 percent) of persons aged 65 and older have ever gone online, but more

than two-thirds (70 percent) of the next generation of seniors (50- to 64-year-olds) have done so (Rideout et al., 2005). In many cases, the current users are relatives of people with disabilities.

Although there is widespread support for providing more information to consumers, the research literature on consumer response to quality of care information in health care is mixed, but mildly positive (Barr et al., 2002; Chernew and Scanlon, 1998; Hibbard et al., 2002; Knutson et al., 1998; McCormack et al., 2001; Short et al., 2002; Vaiana and McGlynn, 2002). And while Nursing Home Compare has received substantial publicity and is well known among policy analysts, its reach into the population at large is more limited. A recent study using focus groups found that few consumers used the Internet to obtain information for an impending nursing home placement, and few participants in the focus groups were aware of Nursing Home Compare (Shugarman and Brown, 2006). Moreover, Stevenson (2006) found that the impact of Nursing Home Compare on occupancy rates for facilities with high- and low-quality rankings was minimal.

Several factors may make consumer information on nursing homes less effective in influencing consumer choice than information for other health care, such as managed care or health insurance plans: First, the information provided is fairly technical, and it is not clear that consumers understand it. The Nursing Home Compare website, for example, lacks a summary rating for a facility or a star system, as is typically found in *Consumer Reports*. However, research on nursing homes surprisingly suggests that quality of care is not highly correlated across care domains (Mukamel and Brower, 1998; Mukamel and Spector, 2002; Porell and Caro, 1998). Thus, some facilities and agencies may rate highly on some dimensions of care but poorly on others. Second, the ability of information to guide decisions is only as good as the information provided. As noted above, some observers contend that MDS information may be inaccurate since it is filled out by providers.

Third, there may be structural problems in the nursing home market that limit competition based on quality. For example, high nursing home occupancy rates in many parts of the country (American Health Care Association, 2007a) potentially limit consumer choice of providers. High nursing facility occupancy rates may also reduce the desire of facilities to compete based on quality since they can fill their beds at lower-quality levels (Cohen and Spector, 1996; Grabowski, 2001; Nyman, 1985). High occupancy rates especially may limit competition for Medicaid nursing facility residents, for whom reimbursement is lower than for private pay residents.

Fourth, characteristics of the nursing home placement process may make use of consumer information difficult. Many nursing home decisions are made on an urgent basis (e.g., discharge from the hospital), and consumers may not have the time to thoroughly research a variety of nursing homes. Individual consumers are usually quite sick, disabled, or cognitively impaired, making it hard for them to be active consumers; friends and relatives often act as decision makers in their place. Placements in nursing homes often involve a great deal of family stress and emotion (Shugarman and Brown, 2006). Moreover, conventional wisdom holds that searches for nursing home agencies are typically made in very small geographic areas, limiting the number of possible provider choices (Mukamel and Spector, 2003). In some areas, especially rural communities, there may be only one provider, making quality-of-care data less compelling to consumers because there are no alternatives.

Providing More Home and Community-Based Services

Probably the most common critique of the long-term care delivery system is that there is an institutional bias. Indeed, most people strongly prefer to remain in the community. First, older people strongly prefer home and community-based services to institutional care. In one study, 30 percent of older people indicated that they would rather die than move to an institutional setting, with an additional 26 percent "very unwilling" (Mattimore et al., 1997). A 2003 study found that 81 percent of persons over age 50 would prefer to avoid nursing home care even if they needed 24-hour care (AARP, 2003).

Over the last 20 years, states, prodded by the federal government, have worked to expand and reform the role of home and community-based service. The U.S. Congressional Budget Office (2004) estimated that 32 percent of total (public and private) long-term care spending for older people was for home and community-based services in 2004. In FY 2006, home and community-based services were 29 percent of Medicaid long-term care expenditures for older people and working-age adults with physical disabilities (Burwell et al., 2007). With the rebalancing of the long-term care system underway, more and more people with disabilities will be receiving services outside of nursing homes, either at home or in residential care facilities such as assisted living facilities.

Quality Assurance for Home Care

Developing standards for and measuring quality of home care is difficult, partly because of the special characteristics of home care (Wiener and Tilly, 2003). First, home and community-based services cover a very large number of disparate services—from highly technical, medical services to nonskilled homemaker services. Thus, some standards that would make sense for

some services do not apply to others. Second, by definition, home care takes place in a very large number of physically dispersed locations, making data collection difficult and expensive. Third, it is an open question as to the extent that providers should be held accountable for adverse client outcomes given that most home care workers spend only a limited amount of time in a consumer's home, unlike the situation in nursing homes (Kane et al., 1994). Fourth, quality measures are not well developed and collecting data from persons with cognitive impairments is difficult and expensive to do adequately. Fifth, states are reluctant to establish detailed standards for home care because they fear replicating the rigidity of the nursing home setting.

Nonskilled home care services, such as personal care, are subject to much less regulation than either nursing facilities or home health agencies (Wiener et al., 2002; Wiener and Tilly, 2003). Medicaid home and community-based services waivers require states to have a quality assurance plan as part of these programs, but the content of those plans is left up to each state. CMS assesses state Medicaid quality assurance plans to ensure that states fulfill basic procedures in ensuring quality of care for services provided under the waiver. In a review of Medicaid waiver programs for older people, the Government Accountability Office (2003) found that there were quality problems in many of them. No federal requirements apply to Medicaid personal care services that are provided outside of the home and community-based services waivers. In response, CMS is requiring more detail on state plans for quality assurance under the waiver. There are no specific federal quality requirements for personal care and other home care services.

A major new development in home and community-based services is the expansion of consumer-directed home care, where the consumer rather than an agency is responsible for the hiring, scheduling, directing, monitoring, and firing of the worker (Infield, 2005; Wiener et al., 2002). CMS is promoting consumer-directed services through the Real Choice Systems Change Grants and the Independence Plus Initiative (O'Keeffe et al., 2005). A number of other countries, including the United Kingdom, Germany, and the Netherlands, are also promoting this type of care (Wiener et al., 2003). For those persons who do not feel comfortable with or are not able to be so actively involved in the decision-making process, more traditional agency-directed care remains available (Tilly and Wiener, 2001).

Compared with agency-directed care, consumer-directed services lack the standard quality assurance structures of required training of paraprofessionals, supervision by professionals, licensing, and inspections. Most states (and countries) have taken fairly minimalist approaches to monitoring quality, relying mostly on complaints and case manager interaction with clients to identify problems (Tilly and Wiener, 2001; Wiener et al., 2003). In place of

formal quality assurance mechanisms, consumer-directed programs rely on the ability of clients to fire unsatisfactory workers and to hire replacements to assure quality—in other words, the market. In addition, a substantial portion of consumer-directed workers are family members or friends, who may be more likely than a stranger to want to provide high-quality care. Despite the lack of regulation, a growing body of research suggests that consumer-directed services are at least as good as and may be better than agency-directed care (Benjamin et al., 1998; Foster et al., 2003; Schore et al., 2007; Wiener et al., in press).

Expansion of Residential Care Facilities, including Assisted Living Facilities

Residential care facilities, such as assisted living facilities, adult family homes, and board and care homes, are an important and growing component of long-term care services. Because of a lack of standard definitions across states, the estimates of the number of residential care facilities and residents vary widely, but range from 400,000 to 800,000 persons aged 65 or older (Spillman and Black, 2005). A recent study of state-licensed residential care estimated that there were 36,500 residential care facilities nationally with 937,601 units/beds in 2004 (Mollica, Johnson-Lamarche, and O'Keeffe., 2005). A substantial portion of residential care facility residents overlap with nursing home residents; for example, a study of assisted living facilities in 1998 found that almost a quarter of residents had problems with three or more of the activities of daily living and a third of residents were cognitively impaired (Hawes, Phillips, and Rose, 2000). State interest in this form of care is fueled by a desire to offer a full array of home and community services, reduce nursing home utilization, and achieve the economies of scale of nursing home care without the undesirable institutional characteristics.

There is no federal regulation of residential care facilities except under Medicaid home and community-based services waivers. While the vast majority of persons in residential care facilities pay privately, approximately 121,000 residents in 2004 received Medicaid funds to help pay for their care, largely through home and community-based services waivers and the personal care option (Mollica et al., 2005). Oregon and Washington are two states that rely heavily on assisted living facilities, adult family homes, and other forms of residential care facilities to serve people with disabilities. In 2004, 37 states had Medicaid home and community-based services waivers covering residential care facilities. Twenty-nine states and the District of Columbia reported in 2004 that they include provisions regarding assisted living concepts such as privacy, autonomy, and decision making in their residential care regulations or Medicaid standards.

Most residential care facility residents pay privately, but Medicaid and Supplemental Security Income beneficiaries are increasing (O'Keeffe and Wiener, 2004). States have almost

total responsibility for non-nursing home residential care. As a result, there is no standardization across states in terms of definition of various types of residential care, and state regulatory requirements vary greatly (Mollica, 2002). Thus, it is impossible to compare facilities across states (Mollica, 2002; O'Keeffe and Wiener, 2004). Many facilities lack the amenities, services, and philosophy of more comprehensive, high-service settings (Hawes et al., 2000). In a change from 10 years ago, all states now license or regulate residential care facilities, although the standards, inspections, and enforcement vary greatly. As a result, little is known about quality of care and quality of life in residential care facilities for people with disabilities, including compliance with state regulations, staffing patterns, or resident outcomes.

While the growth of these facilities would seem to be a market response that consumers want these type of services, there is reason to be concerned about quality of care. A study of six states that use Medicaid to pay for services in residential care settings found stakeholders almost universally concerned about perceptions of insufficient and untrained staff and the potential impact on quality of care (O'Keeffe et al., 2003). Similarly, a U.S. General Accounting Office (1999) study of residential care and assisted living in four states found insufficient, inadequate, and untrained staff, as well as significant rates of medication errors. The National Study of Assisted Living for the Frail Elderly in 1998 found many positive aspects of assisted living facilities, but also found that residents reported unmet needs for assistance with using the toilet (26 percent), locomotion (12 percent), and dressing (12 percent). Most residents (58 percent) also reported that adequate numbers of staff were not always available (Hawes et al., 2000). Finally, articles in the popular media have raised concerns about quality and inadequate staffing in residential care facilities (McCoy & Appleby, 2004a, b; McCoy & Hansen, 2004).

FUTURE OUTLOOK

The Omnibus Budget Reconciliation Act of 1987 was designed to address a range of poor-quality care, such as lack of assessments and care plans, the use of restraints, inadequate staffing, and resident abuse, by establishing new, stronger standards. It was also designed to reform and strengthen the inspection and enforcement process for nursing homes. The passage of this landmark legislation was a rare example of the coming together of all interested parties—consumer advocates, industry, government, and researchers—to improve public policy and was an important example of a government-sponsored commission having a major impact on public policy.

In the 20 years since the passage of OBRA 87, real progress has been made in providing good quality care to nursing home residents. For example, the implementation of the MDS provides facilities with detailed and systematic information on the status of residents that can be used for care planning, to assess improvement and decline in resident status, and to identify quality of care problems. While the information is available to facilities, it is not clear how much nursing homes use it. The use of physical restraints has declined substantially and the organizational culture that promoted their use has declined. In terms of staffing, registered nurse staffing increased with the mandates of OBRA 87 and aides are now required to have at least a modest amount of training before starting to care for residents. And, finally, there has been a marked decline in the proportion of facilities that have been cited for putting residents in immediate jeopardy or causing actual harm, although it is a matter of considerable dispute as to whether it is actually instead a measure of the decline in the vigor of enforcement.

While improvements in care have occurred, significant problems remain. Although there was an initial upgrading of the quality of care as a result of OBRA 87, improvements appeared to have plateaued. Substantial proportions of nursing homes are still cited for inadequate care. Staffing levels have been stable for many years, despite the increased acuity and disability of residents. The best available studies suggest that the vast majority of nursing homes are significantly understaffed and that Medicare prospective payments may have unintentionally contributed to this situation. While CMS has made a number of improvements in its enforcement system, many of the problems identified in the original Institute of Medicine report—underreporting of serious deficiencies, failure to impose sanctions, long delays between initial citation and imposition of sanctions, and poor quality facilities cycling in and out of compliance—remain.

In looking to the future of improving quality of services in long-term care, several issues emerge:

- *The public sector bears a special responsibility for ensuring quality of long-term care.* Many people using long-term care services are severely ill or have physical or cognitive disabilities that make it difficult for them to successfully advocate for themselves. In addition, nursing homes, in particular, are total institutions, where people live their lives 24 hours a day, making them vulnerable to retribution if they complain or make trouble. People with disabilities living in the community can likewise be dependent on their home care workers for such basic activities as getting out of bed, again making it difficult for them to complain about services. Moreover, much more than for acute care, long-term care is dominated by public spending—Medicare, Medicaid, and state programs. Thus, policymakers have a fiduciary responsibility to make sure that the public's money is well spent.

- *Nursing homes will continue to be an important component of long-term care, but more and more people will receive their care at home or in residential care facilities, such as assisted living facilities, leading some to question whether the reach of patient protections should be broadened.* At the time of the passage of OBRA 87, nursing home care was almost the only service option for people with disabilities in many states. Expansion of public funding for home care, principally through Medicare and Medicaid, and private financing for residential care facilities has changed the long-term care landscape significantly. Ensuring quality of care in these settings faces many practical challenges, such as the multiplicity of services, the lack of standards, and the geographic dispersion of the beneficiaries.
- *Staffing issues—staffing levels, stability, and training—continue to be seen as critical to the quality of care in nursing homes.* The existing shortage of staff suggests that convincing additional people to work in long-term care will require higher wages and benefits, as well as changes in organizational culture. Thus, achieving higher staffing ratios and training will likely require giving existing workers better compensation than they currently receive. Given the heavy dependence of long-term care on Medicare and Medicaid, additional funding would be required from federal and state governments. To date, government has been unwilling to make this investment, but it is likely that the pace of quality improvement in nursing homes will be slow without more staff.
- *New organization structures for nursing home ownership and operation may present new challenges in providing high-quality care.* While very little is known about them, the recent involvement of private-equity companies in nursing home care has been accompanied by complex corporate structures that may reduce the ability to hold individuals and organizations accountable for the care that is provided in these facilities (Duhigg, 2007). On the other hand, the private equity firms involved contend that they are providing vital funds to an industry that has had little access to capital markets and that they are concerned about quality of care.
- *Many quality initiatives are geared toward punishing or avoiding inferior-quality care rather than establishing incentives for providers to provide good—even high-quality—care.* Demonstration projects could be developed that provide financial incentives to high quality of care. Although conceptually appealing, these projects face substantial technical problems and the risk of providing financial rewards to providers that are of low quality is not trivial. However, government regulation is a blunt instrument, and the inevitable reality is that surveyors can only directly observe care a very small percentage of the time. Ultimately, long-term care providers are responsible for the care provided in their facilities and by their organizations.
- *While there is general consensus about the quality of care standards established by OBRA 87, consumer advocates and the nursing home industry are far apart in terms of enforcement.* Consumer advocates argue for stricter, more consistent enforcement of the standards, with the explicit goal of eliminating poor performers from the field. They focus on the policing function of inspectors in nursing home regulation. The industry, on the other hand, contends that it is well-meaning in the care that it provides, even when the care is not always perfectly provided, and feels that nursing homes should be appropriately compensated for improvements.

- The political saliency of long-term care quality issues and the consistency of government attentiveness to the issue are uneven. Interest by policymakers tends to be cyclical. Quality of care scandals publicized by the media tend to focus attention on these issues only for a limited period of time. The stories about poor-quality care subside and the topic fades from attention, especially for top policymakers who have competing demands for their attention. It is hard to make progress without sustained attention by high-level policymakers.

In the 20 years since the passage of OBRA 87, real progress has been made in providing improved quality care to nursing home residents, yet significant problems remain. Many of the problems identified in the original Institute of Medicine report persist. The 20th anniversary of the nursing home reform amendments provides an important opportunity to consider lessons learned, assess options for the future, and strategies for caring for an aging population in a variety of long-term are settings.

REFERENCES

AARP (2003). *Beyond 50: A Report to the Nation on Independent Living and Disability.* Washington, DC: AARP. Available at: http://www.aarp.org/research/housing-mobility/homecare/aresearch-import-752-D17817.html.

Administration on Aging (2007). *2005 National Ombudsman Reporting System Data Tables.* Available at: http://www.aoa.gov/prof/aoaprog/elder_rights/LTCombudsman/National_and_State_Data/2005nors/2005nors.asp.

American Health Care Association (2007a). Trends in nursing facility characteristics, July 2007. Washington, DC. Available at: http://www.ahcancal.org/research_data/trends_statistics/Documents/trends_nursing_facilities_quality_measures_Jul2007.pdf.

American Health Care Association (2007b). Trends in publicly reported nursing facility quality measures. Washington, DC. Available at: http://www.ahcancal.org/research_data/trends_statistics/Documents/trends_nursing_facilities_characteristics_Jun2007.pdf

Arling, G., Kane, R., Lewis, T., and Mueller, C. (2005). Future development of nursing home quality indicators. *The Gerontologist,* 45: 147–156.

Barr, J.K., Boni, C.E., Kochurka, K.A., Nolan, P., Petrillo, M., Sofaer, S., and Waters, W. (2002). Public reporting of hospital patient satisfaction: The Rhode Island experience. *Health Care Financing Review,* 23(4): 51–70.

BDO Seidman (2007). *A Report on Shortfalls in Medicaid Financing for Nursing Home Care.* Washington, DC: American Health Care Association. Available at: http://www.ahcancal.org/research_data/funding/Documents/2007_Report_on_Shortfalls_in_Medicaid_Funding.pdf.

Benjamin, A.E., Matthias, R.E., and Franke, T.M. (1998). *Comparing Client-Directed and Agency Models for Providing Supportive Services at Home.* Final report to the U.S. Department of Health and Human Services. Los Angeles: UCLA School of Public Policy.

Bishop, C.E. (1988). Competition in the market for nursing home care. *Journal of Health Politics, Policy and Law,* 13(2): 341–60.

Bostick, J.E., Rantz, M.J., Flesner, M.K., and Riggs, C.J. (2006). Systematic review of studies of staffing and quality in nursing homes. *Journal of the American Medical Directors Association,* 7(6): 366–376.

Burwell, B., Sredl, K., and Eiken, S. (2007). *Medicaid Expenditures for Long-Term Care in FY 2005. Memorandum.* Cambridge, MA: Thomson Healthcare.

Capezuti, E., Evans, L., Strumpf, N., and Maislin, G. (1996). Physical restraint use and falls in nursing home residents. *Journal of the American Geriatrics Society,* 44:627-633.

Capezuti, E., Boltz, M., Renz, S., Hoffman, D., and Norman, R.G. (2006). Nursing home involuntary relocation: Clinical outcomes and perceptions of residents and families. *Journal of the American Medical Directors Association,* 7(8): 486–492.

Carter, M.W., and Porell, F.W. (2006). Nursing home performance on select publicly reported quality indicators and resident risk of hospitalization: Grappling with policy implications. *Journal of Aging and Social Policy*, 18(1): 17–39.

Castle, N.G., and Mor, V. (1998). Physical restraints in nursing homes: A review of the literature since the Nursing Home Reform Act of 1987. *Medical Care Review and Research,* 53(2): 139–170.

Centers for Medicare and Medicaid Services (2001). *Appropriateness of Minimum Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final.* Baltimore: Centers for Medicare and Medicaid Services.

Centers for Medicare & Medicaid Services (2002). *Appropriateness of Minimum Staffing Ratios in Nursing Homes.* Report to Congress. Baltimore: Centers for Medicare & Medicaid Services.

Centers for Medicare & Medicaid Services (2004). *Nursing Home Compare Website.* Available at: http://www.medicare.gov/NHCompare/Static/Related/DataCollection.asp?dest=NAV|Home|Data Details|DataCollection#TabTop.

Centers for Medicare & Medicaid Services (2005). *Medicare "Pay for Performance (P4P)" Initiatives.* Available at: http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1343.

Centers for Medicare & Medicaid Services (2007). *Groundbreaking Medicare Payment Demonstration Results in Substantial Improvement for Hospital Patient Care.* Available at: http://www.cms.hhs.gov/apps/media/press_releases.asp.

Chernew, M., and Scanlon, D.P. (1998). Health plan report cards and insurance choice. *Inquiry*, 35(1): 9–22.

Code of Federal Regulations, Title 42, Volume 3, Part 483 (Revised October 1, 2000). *Requirements for States and Long-Term Care Facilities.* Washington, DC: U.S. Government Printing Office via GPO Access.

Cohen, J.W., and Spector, W.D. (1996). The effect of Medicaid reimbursement on quality of care in nursing homes. *Journal of Health Economics*, 15: 23–28.

Cousineau, M., Regan, C., and Kokkinis, A. (2000). *A Crisis for Caregivers: Health Insurance Out of Reach for Los Angeles Home Care Workers.* Oakland, CA: California Healthcare Foundation.

Crown, W., Ahlburg, D.A., and MacAdam, M. (1995). The demographic and employment characteristics of home care aides: A comparison with nursing home aides, hospital aides, and other workers. *Gerontologist*, 35(2): 162–170.

Decker, F.H. (2005). *Nursing Homes, 1977–99: What Has Changed, What Has Not?* Hyattsville, MD: U.S. Department of Health and Human Services, CDC, National Center for Health Statistics. Available at: http://www.cdc.gov/nchs/data/nnhsd/nursinghomes1977_99.pdf.

Decker, F.H., Gruhn, P., Matthews-Martin, L., Dollard, K.J., Tucker, A.M., and Bizette, L. (2003). *2002 AHCA Survey Nursing Staff Vacancy and Turnover in Nursing Homes.* Washington, DC: American Health Care Association.

Duhigg, C. (2007). At many homes, more profit and less nursing. *New York Times.* September 23. p. 1, 20–21.

Ejaz, F.K., Jones, J.A., and Rose, M.S. (1994). Falls among nursing home residents: An examination of incident reports before and after restraint reduction programs. *Journal of the American Geriatrics Society* 42: 960–964.

Foster, L., Brown, R., Phillips, B., Schore, J., and Carlson, B.L. (2003). Improving the quality of Medicaid personal assistance through consumer direction. *Health Affairs*, Jan-Jun(Suppl): W3-162–75.

Graber, D.R., and Sloan, P.D. (1995). Nursing home survey deficiencies for physical restraint use. *Medical Care,* 33(10): 1051–1063.

Grabowski, D.C. (2001). Medicaid reimbursement and quality of nursing home care. *Journal of Health Economics,* 20: 549–569.

Grabowski, D.C. (2004). A longitudinal study of Medicaid payment, private-pay price and nursing home quality. *International Journal of Health Care Finance and Economics,* 4: 5–26.

Grabowski, D.C., and Angelelli, J.J. (2004). The relationship of Medicaid payment rates, bed constraint policies, and risk adjusted pressure ulcers. *Health Services Research,* 39(4 Pt 1): 793–812.

Grabowski, D.C., Angelelli, J.J., and Mor, V. (2004). Medicaid payment and risk adjusted nursing home quality measures. *Health Affairs,* 23(5): 243–252.

Harrington, C., and Carrillo, H. (1999). The regulation and enforcement of federal nursing home standards. *Medical Care Research and Review*, 56(4): 471–494.

Harrington, C., and Carrillo, H. (2000). *Analysis of HCFA's On-Line Survey, Certification and Reporting (OSCAR) System Data*. San Francisco: University of California.

Harrington, C., Carrillo, H., and Blank, B. (2007). *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2000 Through 2006*. San Francisco: Department of Social and Behavioral Sciences, University of California.

Harrington, C., Carrillo, H., and Crawford, C. (2004). *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1997 Through 2003*. San Francisco: Department of Social and Behavioral Sciences, University of California.

Harrington, C., Carrillo, H., and LaCava, C. (2006). *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1999 Through 2005*. San Francisco: Department of Social and Behavioral Sciences, University of California.

Harrington, C., Carrillo, H., and Mercado-Scott, C. (2005). *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1998 Through 2004*. San Francisco: Department of Social and Behavioral Sciences, University of California.

Harrington, C., Carrillo, H., and Wellin, V. (2001). *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1994 Through 2000*. San Francisco: Department of Social and Behavioral Sciences, University of California.

Harrington, C., Carrillo, H., Wellin, V., and Burdin, A. (2003a). *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1996 Through 2002*. San Francisco: Department of Social and Behavioral Sciences, University of California.

Harrington, C., Carrillo, H., Wellin, V., and Shemirani, B. (2002). *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1995 Through 2001*. San Francisco: Department of Social and Behavioral Sciences, University of California.

Harrington, C., and Millman, M. (2001). Nursing home staffing standards in state statutes and regulations. Report prepared for the Henry J. Kaiser Family Foundation, San Francisco: University of California, San Francisco.

Harrington, C., Mullan, J.T. and Carrillo, H. (2004). State nursing home enforcement systems. *Journal of Health Politics, Policy and Law*, 29: 43–73.

Harrington, C., O'Meara, J., Kitchener, M., Simon, L.P., and Schnelle, J.F. (2003b). Designing a report card for nursing facilities: What information is needed and why. *Gerontologist,* 43(Special Issue II), 47–57.

Harrington, C., Zimmerman, D., Karon, S., Robinson, J., and Beutel, P. (2000). Nursing home staffing and its relationship to deficiencies. *Journal of Gerontology—Social Sciences*, 55B(5): S278-S287.

Hawes, C. (1996). *Assuring Nursing Home Quality: The History and Impact of Federal Standards in OBRA-1987.* New York: The Commonwealth Fund.

Hawes, C. (1997). Regulation and the politics of long-term care. *Generations*, 21(4): 5–13.

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.

Hawes, C., More., V., Phillips, C.D., Fries, B.E., Morris, J.N., Steele-Friedlob, E., Greene, A.M., and Nennstiel, M. (1997). The OBRA-87 nursing home regulations and the implementation of the resident assessment instrument: Effects on process quality. *Journal of the American Geriatric Society*, 45: 977–985.

Hawes, C., Phillips, C.D, and Rose, M. (2000). *A National Study of Assisted Living for the Frail Elderly: Results of a National Survey of Facilities.* Report prepared for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Available at: http://aspe.hhs.gov/daltcp/reports facres.htm.

Hibbard, J.H., Stockard, J., and Tusler, M. (2002). Does publicizing hospital performance stimulate quality improvement efforts? *Health Affairs*, 22(2): 84–94.

Infield, D.L. (2005). *States' Experiences Implementing Consumer-Directed Home & Community Services: Results of the 2004 Survey of State Administrators, Opinion Survey & Telephone Interviews.* National Association of State Units on Aging and the National Council on the Aging. Available at: http://www.nasua.org/pdf/20026_text.pdf.

Institute of Medicine (1986). *Improving the Quality of Care in Nursing Homes.* Washington, DC: National Academy Press.

Institute of Medicine (2001). *Improving the Quality of Long-Term Care.* Washington, DC: National Academy Press.

Institute of Medicine (2003). *Keeping Patients Safe: Transforming the Work Environment of Nurses.* Washington, DC: National Academy Press.

Kane, R.A., Kane, R.L., Illston, L.H., and Eustis, N.N. (1994). Perspectives on home care quality. *Health Care Financing Review,* 16(1): 69–90.

Kane, R.L., Arling, G., Mueller, C., Held, R., and Cooke, V. (2007). A quality-based payment strategy for nursing home care in Minnesota. *The Gerontologist,* 47: 108-115.

Kasper, J., and O'Malley, M. (2007). *Changes in Characteristics, Needs, and Payment for Care of Elderly Nursing Home Residents: 1999 to 2004.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Publication #7663. Available at: http://www.kff.org/medicaid/7663.cfm.

Komisar, H., and Thompson, L.S. (2007). National spending for long-term care. Washington, DC: Georgetown University. Available at: http://ltc.georgetown.edu/pdfs/natspendfeb07.pdf.

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): 270–276.

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.

Knutson, D.J., Kind, E.A., Fowles, J.B., and Adlis, S. (1998). Impact of report cards on employees: A natural experiment. *Health Care Financing Review,* 20: 5–27.

Lee, R.H., Gajewski, B.J., and Thompson, S. (2006). Reliability of the nursing home survey process: A simultaneous survey approach. *Gerontologist,* 46(6), 772–780.

Mattimore T.J., et al. (1997). Surrogate and physician understanding of patients' preferences for living permanently in a nursing home. *Journal of the American Geriatrics Society,* 45: 818-824.

McCormack, L.A., Anderson, W.L., Uhrig, J., Garfinkel, S., Sofaer, S., and Terrell, S. (2001). Health plan decision making in the Medicare population: Results from a national randomized experiment. *Health Services Research,* 36(6)(Part II): 133–149.

McCoy, K., & Hansen, B. (2004, May 24). Havens for elderly may expose them to deadly risks. *USA Today.*

McCoy, K., and Appleby, J. (2004, May 26). Many facilities accept people who are too ill. *USA Today,* p.A06.

McCoy, K., & Appleby, J. (2004b, May 26). Problems with staffing, training can cost lives. *USA Today,* p. B01.

Mollica, R. (2002). *State Assisted Living Policy: 2002.* Portland, ME: National Academy for State Health Policy.

Mollica, R., Johnson-Lamarche, H., and O'Keeffe, J. (2005). *State Residential Care and Assisted Living Policy.* Washington, DC: U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy. Available at: http://aspe.hhs.gov/daltcp/reports/04alcom.htm.

Mukamel, D.B., and Brower, C.A. (1998). The influence of risk adjustment methods on conclusions about quality of care in nursing homes based on outcome measures. *Gerontologist,* 38: 367–385.

Mukamel, D.B., and Spector, W.D. (2003). Quality report cards and nursing home quality. *Gerontologist,* 43(Special Issue II): 58-66.

National Citizens' Coalition for Nursing Home Reform (1985). *A consumer perspective on quality care: The residents' point of view.* Washington, DC: National Citizens' Coalition for Nursing Home Reform.

New York State Moreland Act Commission on Nursing Homes and Residential Facilities (1975). *Regulating Nursing Home Care: The Paper Tigers*. Report of the New York State Moreland Act Commission.

Noelker, L.S., and Harel, Z. (eds.). (2000). *Quality of life and quality of care in long-term care*. New York: Springer Publishing Company.

Norton, E.C. (1992). Incentive regulation of nursing homes. *Journal of Health Economics,* 26(2): 105–128.

Nyman, J.A. (1985). Prospective and cost-plus Medicaid reimbursement, excess demand and the quality of nursing homes. *Journal of Health Economics,* 4: 237–259.

Nyman, J.A. (1988). Improving the quality of nursing home outcomes: Are adequacy- or incentive-oriented policies more effective? *Medical Care,* 26(12): 1158-1171.

O'Keeffe, J., O'Keeffe, C., and Bernard, S. (July 2003). *Examination of Medicaid's Role in Residential Care Settings for Elderly Persons: Final Report*. RTI Project Report prepared for the Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation/Division on Disability, Aging, and Long Term Care.

O'Keeffe, J., and Wiener, J.M. (2004). Public funding for long-term care services for older people in residential care settings. *Journal of Housing for the Elderly,* 18(3/4): 51–80.

O'Keeffe, J., Wiener, J.M., and Greene, A. (2005). *Consumer Direction Initiatives of the FY2001 and FY2002 Systems Change Grantees: Progress and Challenges*. Report to the Centers for Medicare & Medicaid Services. Research Triangle Park, NC: RTI International.

Phillips, C.D., Hawes, C., Mor, V., Fries, B.E., Morris, J., and Nennstiel, M. (1996). Facility and area variation affecting the use of physical restraints in nursing homes. *Medical Care,* 334(11): 1149–1162.

Porell, F., and Caro, F.G. (1998). Facility-level outcome performance measures for nursing homes. *Gerontologist,* 38, 665–683.

Rabig, J., Thomas, W., Kane, R.A., Cutler, L.J., and McAlilly, S. (2006). Radical redesign of nursing homes: Applying the Green House concept in Tupelo, Mississippi. *Gerontologist,* 46: 533–539. Available at: http://gerontologist.gerontologyjournals.org/cgi/content/abstract/46/4/533.

Rideout, V., Neuman, T., Kitchman, M., and Brodie, M. (2005). *e-Health and the Elderly: How Seniors Use the Internet for Health Information*. Washington, DC: Kaiser Family Foundation. Available at: http://www.kff.org/entmedia/7223.cfm.

Schore, J., Foster, L., and Phillips, B. (2007). Consumer enrollment and experiences in the cash and counseling program. *Health Services Research,* 42(1)(Part II): 446–466.

Scully, T.A. (2003). Testimony on nursing home quality. Testimony before the U.S. Senate Finance Committee. Washington, DC.

Short, P., McCormack, L., Hibbard, J., Shaul, J., Harris-Kojetin, L., Fox, M., Damino, P., Uhrig, J., and Cleary, P. (2002). Similarities and differences in choosing health plans. *Medical Care,* 40(4): 1–14.

Shugarman, L.R., and Brown, J.A. (2006). *Nursing Home Selection: How do Consumers Choose? Volume I: Findings from Focus Groups of Consumers and Information Intermediaries*. RAND Corporation, Washington, DC: Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Available at: http://aspe.hhs.gov/daltcp/reports/2006/chooseI.pdf.

Shugarman, L.R., and Garland, R. (2006). *Nursing Home Selection: How do Consumers Choose? Volume II: Findings from the Website Content Review*. Rand Corporation.

Spillman, B.C., and Black, K.J. (2005). *Staying the Course: Trends in Family Caregiving*. AARP #2005-17. Washington, DC: AARP Public Policy Institute. Available at: www.aarp.org/research/longtermcare/trends/2005_17_caregiving.html.

Stevenson, D.G. (2006). Is a public reporting approach appropriate for nursing home care? *Journal of Health Politics, Policy and Law,* 31(4): 773–810.

Stone, R.I., and J.M. Wiener (2001). *Who Will Care for Us? Addressing the Long-Term Care Workforce Crisis*. Washington, DC: The Urban Institute.

Stuart, M., and Weinrich, M. (2001). Home is where the help is: Community-based care in Denmark. *Journal of Aging and Social Policy,* 12(4): 81–101.

Strumpf, N.E., and Tomes, N. (1993). Restraining the troublesome patient: A historical perspective on a contemporary debate. *Nursing History Review*, 1: 3–24.

Sundel, M.R., Garret, R.M., and Horn, R.D. (1994). Restraint reduction in a nursing home and its impact on employee attitudes. *Journal of the American Geriatrics Society*, 42(4): 381–837.

Thomas, W.H. (1994). *The Eden Alternative: Nature, Hope, and Nursing Homes*. Sherburne, NY: Eden Alternative Foundation.

Tilly, J. and Wiener, J.M. (2001). Consumer-directed home and community services programs in eight states: Policy issues for older people and government. *Journal of Aging and Social Policy*, 12(4): 1–26.

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.

U.S. Congressional Budget Office (2004). *Financing Long-Term Care for the Elderly*. Washington, DC: U.S. Congressional Budget Office.

U.S. Department of Health and Human Services (2007). *Budget in Brief: Fiscal year 2007*. Washington, DC. Available at: http://www.hhs.gov/budget/07budget/2007BudgetInBrief.pdf.

U.S. Department of Health and Human Services, Office of the Inspector General (2002). *State Nurse Aide Training: Program Information and Data*. Washington, DC: Office of Evaluation and Inspections, Office of the Inspector General, U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services, Office of the Inspector General (2005). *Nursing Home Enforcement: The Use of Civil Money Penalties*. Washington, DC: Office of the Inspector General, U.S. Department of Health and Human Services.

U.S. General Accounting Office (1987). *Medicare and Medicaid—Stronger Enforcement of Nursing Home Requirements Needed.* Washington, DC: U.S. General Accounting Office.

U.S. General Accounting Office (1999). *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards* (GAO/HEHS-99-46). Washington, DC: U.S. General Accounting Office.

U.S. General Accounting Office (2002). *Medicare Home Health Agencies: Weaknesses in Federal and State Oversight Mask Potential Quality Issues* (GAO-02-382). Washington, DC: U.S. General Accounting Office.

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, DC: General Accounting Office.

U.S. Government Accountability Office (2005). *Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety* (GAO-06-117). Washington, DC: U.S. Government Accountability Office.

U.S. Government Accountability Office (2007a). *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents. GAO-07-241.* Washington, DC: U.S. Government Accountability Office.

U.S. Government Accountability Office (2007b). *Nursing Home Reform: Continued Attention is Needed to Improve Quality of Care in Small but Significant Share of Homes. GAO-07-794T.* Washington, DC: U.S. Government Accountability Office.

U.S. Government Printing Office (2000) *Code of Federal Regulations: Title 42, Volume 3, Parts 430 to end.* Available at: http://www.ltcombudsman.org//uploads/ObraFederalRegs.pdf.

U.S. House of Representatives Committee on Government Reform, Minority Staff, Special Investigations Division (2002). *HHS "Nursing Home Compare" Website has Major Flaws.* Washington, DC: U.S. House of Representatives.

U.S. Senate Special Committee on Aging (1974). *Nursing Home Care in the United States: Failure in Public Policy: Introductory Report.* Washington, DC: U.S. Government Printing Office.

Vaiana, M.E., and McGlynn, E.A. (2002). What cognitive science tells us about the design of reports to consumers. *Medical Care Research and Review,* 59(1): 3–35.

Walshe, K., and Harrington, C. (2002) Regulation of nursing facilities in the United States: An analysis of resources and performance of state survey agencies. *The Gerontologist,* 42(4): 475–487.

Weissert, W.G., Scanlon, W.J., Wan, T.T., and Skinner, D.E. (1983). Care for the chronically ill: Nursing home incentive payment experience. *Health Care Financing Review,* 5(2), 41-49.

White, A., Hurd, D. Moore, T., Warner, D., Wu, N., and Sweetland, R. (2006). *Quality Monitoring for Medicare Global Payment Demonstrations: Nursing Home Quality-Based Purchasing Demonstration, Final Design Report.* Centers for Medicare & Medicaid Services Contract # 500-00-0032, T.O. # 1. Cambridge, MA: Abt Associates Inc.

White, C. (2005). Medicare's prospective payment system for skilled nursing facilities: Effects on staffing and quality of care. *Inquiry,* 42(4): 351-366.

Wiener, J.M. (1981). *A Sociological Analysis of Government Regulation: The Case of Nursing Homes* (unpublished Ph.D. dissertation). Cambridge, MA: Harvard University.

Wiener, J.M., Anderson, W.L., and Khatutsky, G.A. (In press). Are consumer-directed home care beneficiaries satisfied? Evidence from Washington State. *Gerontologist.*

Wiener, J.M., and Stevenson, D.G. (1998). *Long-Term Care for the Elderly: Profiles of Thirteen States.* Assessing the New Federalism Occasional Paper No. 12. Washington, DC: The Urban Institute.

Wiener, J.M., and Tilly, J. (2003). Long-term care and American federalism: Can states be the engine of reform? In Holahan, J., A. Weil, and J.M. Wiener (Eds.), *Federalism and Health Policy.* Washington, DC: The Urban Institute Press, pp. 249–292.

Wiener, J.M., Tilly, J., and Alecxih, L.M.B. (2002). Home and community-based services for older persons and younger adults with disabilities in seven states. *Health Care Financing Review,* 23(3): 89–114.

Wiener, J.M., Tilly, J., and Cuellar, A.E. (2003). Consumer-directed home care in the Netherlands, Germany and England. Washington, DC: AARP. Available at: http://www.aarp.org/research/.

Yamada, Y. (2002). Profile of home care aides, nursing home aides, and hospital aides: Historical changes and data recommendations. *Gerontologist,* 42(2): 199–206.

Zhang, X., and Grabowski, D.C. (2004). Nursing home staffing and quality under the Nursing Home Reform Act. *The Gerontologist,* 44(1): 13–23.

Zimmerman, D.R., Karon, S.L., Arling, G., Clark, B.R., Collins, T., Ross, R., and Sainfort, F. (1995). Development and testing of nursing home quality indicators. *Health Care Financing Review,* 16(4): 107–127.

APPENDIX

CMS Nursing Home Compare Quality Measures

Quality Measures	MDS Observation Time Frame*
Long-Stay Measures	
Percent of Long-Stay Residents Given Influenza Vaccination During the Flu Season	October 1 thru March 31
Percent of Long-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination	Looks back 5 years
Percent of Long-Stay Residents Whose Need for Help With Daily Activities Has Increased	Looks back 7 days
Percent of Long-Stay Residents Who Have Moderate to Severe Pain	Looks back 7 days
Percent of High-Risk Long-Stay Residents Who Have Pressure Sores	Looks back 7 days
Percent of Low-Risk Long-Stay Residents Who Have Pressure Sores	Looks back 7 days
Percent of Long-Stay Residents Who Were Physically Restrained	Looks back 7 days
Percent of Long-Stay Residents Who are More Depressed or Anxious	Looks back 30 days
Percent of Low-Risk Long-Stay Residents Who Lose Control of Their Bowels or Bladder	Looks back 14 days
Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder	Looks back 14 days
Percent of Long-Stay Residents Who Spent Most of Their Time in Bed or in a Chair	Looks back 7 days
Percent of Long-Stay Residents Whose Ability to Move About in and Around Their Room Got Worse	Looks back 7 days
Percent of Long-Stay Residents with a Urinary Tract Infection	Looks back 30 days
Percent of Long-Stay Residents Who Lose Too Much Weight	Looks back 30 days
Short-Stay Measures	
Percent of Short-Stay Residents Given Influenza Vaccination During the Flu Season	October 1 thru March 31
Percent of Short-Stay Residents Who Were Assessed and Given Pneumococcal Vaccination	Looks back 5 years
Percent of Short-Stay Residents With Delirium	Looks back 7 days
Percent of Short-Stay Residents Who Had Moderate to Severe Pain	Looks back 7 days
Percent of Short-Stay Residents With Pressure Sores	Looks back 7 days

*When multiple MDS items with more than one "look back" timeframe are used to calculate the measure, this table displays the longest "look back" timeframe.

The Henry J. Kaiser Family Foundation

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

Additional copies of this report (#7717) are available on the
Kaiser Family Foundation's website at www.kff.org

NEWS RELEASE

Committee on Energy and Commerce
Rep. John D. Dingell, Chairman

For Immediate Release: October 22, 2007
Contact: Steve Adamske (202) 225-7141 or Heather Wong (202) 226-3314/Financial Services or Brin Frazier (202) 225-5735/Energy & Commerce

Chairmen Dingell, Frank to Meet with Nursing Home Workers to Discuss Private Equity Ownership of Nursing Homes

Washington, DC – Reps. John D. Dingell (D-MI), Chairman of the House Committee on Energy and Commerce, and Barney Frank (D-MA), Chairman of the House Committee on Financial Services, will meet tomorrow with nursing home workers to discuss the impact of the striking increase in the number of elder care and nursing home facilities being bought by private equity firms. The workers are particularly concerned about maintaining a high quality of care at these facilities and ensuring that private equity ownership does not result in dangerous staffing reductions. Chairmen Dingell and Frank will hold a press availability immediately following the meeting to discuss their concerns.

WHO: Rep. John D. Dingell, Chairman, Energy and Commerce Committee Rep. Barney Frank, Chairman, Financial Services Committee

WHAT: Press availability on the impact of private equity ownership of nursing homes

WHEN: Tuesday, October 23, 2007, 10:30 a.m.

WHERE: Room 2220, Rayburn House Office Building

-30-

Prepared by the Committee on Energy and Commerce
2125 Rayburn House Office Building, Washington, DC 20515

The New York Times
nytimes.com

September 23, 2007

At Many Homes, More Profit and Less Nursing

By CHARLES DUHIGG

Analyzing the Data

For this article, The New York Times analyzed trends at nursing homes purchased by private investment groups by examining data available from the Centers for Medicare and Medicaid Services, a division of the Department of Health and Human Services.

The Times examined more than 1,200 nursing homes purchased by large private investment groups since 2000, and more than 14,000 other homes. The analysis compared investor-owned homes against national averages in multiple categories, including complaints received by regulators, health and safety violations cited by regulators, fines levied by state and federal authorities, the performance of homes as reported in a national database known as the Minimum Data Set Repository and the performance of homes as reported in the Online Survey, Certification and Reporting database.

Habana Health Care Center, a 150-bed nursing home in Tampa, Fla., was struggling when a group of large private investment firms purchased it and 48 other nursing homes in 2002.

The facility's managers quickly cut costs. Within months, the number of clinical registered nurses at the home was half what it had been a year earlier, records collected by the Centers for Medicare and Medicaid Services indicate. Budgets for nursing supplies, resident activities and other services also fell, according to Florida's Agency for Health Care Administration.

The investors and operators were soon earning millions of dollars a year from their 49 homes.

Residents fared less well. Over three years, 15 at Habana died from what their families contend was negligent care in lawsuits filed in state court. Regulators repeatedly warned the home that staff levels were below mandatory minimums. When regulators visited, they found malfunctioning fire doors, unhygienic kitchens and a resident using a leg brace that was broken.

"They've created a hellhole," said Vivian Hewitt, who sued Habana in 2004 when her mother died after a large bedsore became infected by feces.

Habana is one of thousands of nursing homes across the nation that large Wall Street investment companies have bought or agreed to acquire in recent years.

Those investors include prominent private equity firms like Warburg Pincus and the Carlyle Group, better known for buying companies like Dunkin' Donuts.

As such investors have acquired nursing homes, they have often reduced costs, increased profits and quickly

resold facilities for significant gains.

But by many regulatory benchmarks, residents at those nursing homes are worse off, on average, than they were under previous owners, according to an analysis by The New York Times of data collected by government agencies from 2000 to 2006.

The Times analysis shows that, as at Habana, managers at many other nursing homes acquired by large private investors have cut expenses and staff, sometimes below minimum legal requirements.

Regulators say residents at these homes have suffered. At facilities owned by private investment firms, residents on average have fared more poorly than occupants of other homes in common problems like depression, loss of mobility and loss of ability to dress and bathe themselves, according to data collected by the Centers for Medicare and Medicaid Services.

The typical nursing home acquired by a large investment company before 2006 scored worse than national rates in 12 of 14 indicators that regulators use to track ailments of long-term residents. Those ailments include bedsores and easily preventable infections, as well as the need to be restrained. Before they were acquired by private investors, many of those homes scored at or above national averages in similar measurements.

In the past, residents' families often responded to such declines in care by suing, and regulators levied heavy fines against nursing home chains where understaffing led to lapses in care.

But private investment companies have made it very difficult for plaintiffs to succeed in court and for regulators to levy chainwide fines by creating complex corporate structures that obscure who controls their nursing homes.

By contrast, publicly owned nursing home chains are essentially required to disclose who controls their facilities in securities filings and other regulatory documents.

The Byzantine structures established at homes owned by private investment firms also make it harder for regulators to know if one company is responsible for multiple centers. And the structures help managers bypass rules that require them to report when they, in effect, pay themselves from programs like Medicare and Medicaid.

Investors in these homes say such structures are common in other businesses and have helped them revive an industry that was on the brink of widespread bankruptcy.

"Lawyers were convincing nursing home residents to sue over almost anything," said Arnold M. Whitman, a principal with the fund that bought Habana in 2002, Formation Properties I.

Homes were closing because of ballooning litigation costs, he said. So investors like Mr. Whitman created corporate structures that insulated them from costly lawsuits, according to his company.

"We should be recognized for supporting this industry when almost everyone else was running away," Mr. Whitman said in an interview.

Some families of residents say those structures unjustly protect investors who profit while care declines.

When Mrs. Hewitt sued Habana over her mother's death, for example, she found that its owners and managers had spread control of Habana among 15 companies and five layers of firms.

As a result, Mrs. Hewitt's lawyer, like many others confronting privately owned homes, has been unable to establish definitively who was responsible for her mother's care.

Current staff members at Habana declined to comment. Formation Properties I said it owned only Habana's real estate and leased it to an independent company, and thus bore no responsibility for resident care.

That independent company — Florida Health Care Properties, which eventually became Epsilon Health Care Properties and subleased the home's operation to Tampa Health Care Associates — is affiliated with Warburg Pincus, one of the world's largest private equity firms. Warburg Pincus, Florida Health Care, Epsilon and Tampa Health Care all declined to comment.

Demand for Nursing Homes

The graying of America has presented financial opportunities for all kinds of businesses. Nursing homes, which received more than $75 billion last year from taxpayer programs like Medicare and Medicaid, offer some of the biggest rewards.

"There's essentially unlimited consumer demand as the baby boomers age," said Ronald E. Silva, president and chief executive of Fillmore Capital Partners, which paid $1.8 billion last year to buy one of the nation's largest nursing home chains. "I've never seen a surer bet."

For years, investors shunned nursing home companies as the industry was battered by bankruptcies, expensive lawsuits and regulatory investigations.

But in recent years, large private investment groups have agreed to buy 6 of the nation's 10 largest nursing home chains, containing over 141,000 beds, or 9 percent of the nation's total. Private investment groups own at least another 60,000 beds at smaller chains and are expected to acquire many more companies as firms come under shareholder pressure to sell.

The typical large chain owned by an investment company in 2005 earned $1,700 a resident, according to reports filed by the facilities. Those homes, on average, were 41 percent more profitable than the average facility.

But, as in the case of Habana, cutting costs has become an issue at homes owned by large investment groups.

"The first thing owners do is lay off nurses and other staff that are essential to keeping patients safe," said Charlene Harrington, a professor at the University of California in San Francisco who studies nursing homes. In her opinion, she added, "chains have made a lot of money by cutting nurses, but it's at the cost of human lives."

The Times's analysis of records collected by the Centers for Medicare and Medicaid Services reveals that at

60 percent of homes bought by large private equity groups from 2000 to 2006, managers have cut the number of clinical registered nurses, sometimes far below levels required by law. (At 19 percent of those homes, staffing has remained relatively constant, though often below national averages. At 21 percent, staffing rose significantly, though even those homes were typically below national averages.) During that period, staffing at many of the nation's other homes has fallen much less or grown.

Nurses are often residents' primary medical providers. In 2002, the Department of Health and Human Services said most nursing home residents needed at least 1.3 hours of care a day from a registered or licensed practical nurse. The average home was close to meeting that standard last year, according to data.

But homes owned by large investment companies typically provided only one hour of care a day, according to The Times's analysis of records collected by the Centers for Medicare and Medicaid Services.

For the most highly trained nurses, staffing was particularly low: Homes owned by large private investment firms provided one clinical registered nurse for every 20 residents, 35 percent below the national average, the analysis showed.

Regulators with state and federal health care agencies have cited those staffing deficiencies alongside some cases where residents died from accidental suffocations, injuries or other medical emergencies.

Federal and state regulators also said in interviews that such cuts help explain why serious quality-of-care deficiencies — like moldy food and the restraining of residents for long periods or the administration of wrong medications — rose at every large nursing home chain after it was acquired by a private investment group from 2000 to 2006, even as citations declined at many other homes and chains.

The typical number of serious health deficiencies cited by regulators last year was almost 19 percent higher at homes owned by large investment companies than the national average, according to analysis of Centers for Medicare and Medicaid Services records.

(The Times's analysis of trends did not include Genesis HealthCare, which was acquired earlier this year, or HCR Manor Care, which the Carlyle Group is buying, because sufficient data were not available.)

Representatives of all the investment groups that bought nursing home chains since 2000 — Warburg Pincus, Formation, National Senior Care, Fillmore Capital Partners and the Carlyle Group — were offered the data and findings from the Times analysis. All but one declined to comment.

An executive with a company owned by Fillmore Capital, which acquired 342 homes last year, said that because some data regarding the company were missing or collected before its acquisition, The Times's analysis was not a complete portrayal of current conditions. That executive, Jack MacDonald, also said that it was too early to evaluate the new management, that the staff numbers at homes over all was rising and that quality had improved by some measures.

"We are focused on becoming a better organization today than we were 18 months ago," he said. "We are confident that we will be an even better organization in the future."

A Web of Responsibility

Vivian Hewitt's mother, Alice Garcia, was 81 and suffering from Alzheimer's disease when, in late 2002, she moved into Habana.

"I couldn't take care of her properly anymore, and Habana seemed like a really nice place," Mrs. Hewitt said.

Earlier that year, Formation bought Habana, 48 other nursing homes and four assisted living centers from Beverly Enterprises, one of the nation's largest chains, for $165 million.

Formation immediately leased many of the homes, including Habana, to an affiliate of Warburg Pincus. That firm spread management of the homes among dozens of other corporations, according to documents filed with Florida agencies and depositions from lawsuits.

Each home was operated by a separate company. Other companies helped choose staff, keep the books and negotiate for equipment and supplies. Some companies had no employees or offices, which let executives file regulatory documents without revealing their other corporate affiliations.

Habana's managers increased occupancy, and cut expenses by laying off about 10 of 30 clinical administrators and nurses, Medicare filings reveal. (After regulators complained, some positions were refilled and other spending increased.) Soon, Medicare regulators cited Habana for malfunctioning fire doors and moldy air vents.

Throughout that period, Formation and the Warburg Pincus affiliate received rent and fees that were directly tied to Habana's revenues, interviews and regulatory filings show. As the home's fiscal health improved, those payments grew. In total, they exceeded $3.5 million by last year. The companies also profited from the other 48 homes.

Though spending cuts improved the home's bottom line, they raised concerns among regulators and staff.

"Those owners wouldn't let us hire people," said Annie Thornton, who became interim director of nursing around the time Habana was acquired, and who left about a year later. "We told the higher-ups we needed more staffing, but they said we should make do."

Regulators typically visit nursing homes about once a year. But in the 12 months after Formation's acquisition of Habana, they visited an average of once a month, often in response to residents' complaints. The home was cited for failing to follow doctors' orders, cutting staff below legal minimums, blocking emergency exits, storing food in unhygienic areas and other health violations.

Soon after, nursing home inspectors wrote in Centers for Medicare and Medicaid Services documents that Habana was at fault when a resident suffocated because his tracheotomy tube became clogged. Although he had complained of shortness of breath, there were no records showing that staff had checked on him for almost two days.

Those citations never mentioned Formation, Warburg Pincus or its affiliates. Warburg Pincus and its affiliates declined to discuss the citations. Formation said it was merely a landlord.

"Formation Properties owns real estate and leases it to an unaffiliated third party that obtains a license to operate it as a health care facility," Formation said. "No citation would mention Formation Properties since it has no involvement or control over the operations at the facility or any entity that is involved in such operations."

For Mrs. Hewitt's mother, problems began within months of moving in as she suffered repeated falls.

"I would call and call and call them to come to her room to change her diaper or help me move her, but they would never come," Mrs. Hewitt recalled.

Five months later, Mrs. Hewitt discovered that her mother had a large bedsore on her back that was oozing pus. Mrs. Garcia was rushed to the hospital. A physician later said the wound should have been detected much earlier, according to medical records submitted as part of a lawsuit Mrs. Hewitt filed in a Florida Circuit Court.

Three weeks later, Mrs. Garcia died.

"I feel so guilty," Mrs. Hewitt said. "But there was no way for me to find out how bad that place really was."

Death and a Lawsuit

Within a few months, Mrs. Hewitt decided to sue the nursing home.

"The only way I can send a message is to hit them in their pocketbook, to make it too expensive to let people like my mother suffer," she said.

But when Mrs. Hewitt's lawyer, Sumeet Kaul, began investigating Habana's corporate structure, he discovered that its complexity meant that even if she prevailed in court, the investors' wallets would likely be out of reach.

Others had tried and failed. In response to dozens of lawsuits, Formation and affiliates of Warburg Pincus had successfully argued in court that they were not nursing home operators, and thus not liable for deficiencies in care.

Formation said in a statement that it was not reasonable to hold the company responsible for residents, "any more, say, than it would be reasonable for a landlord who owns a building, one of whose tenants is Starbucks, to be held liable if a Starbucks customer is scalded by a cup of hot coffee."

Formation, Warburg Pincus and its affiliates all declined to answer questions regarding Mrs. Hewitt's lawsuit.

Advocates for nursing home reforms say anyone who profits from a facility should be held accountable for its care.

"Private equity is buying up this industry and then hiding the assets," said Toby S. Edelman, a nursing home expert with the Center for Medicare Advocacy, a nonprofit group that counsels people on Medicare. "And

now residents are dying, and there is little the courts or regulators can do."

Mrs. Hewitt's lawyer has spent three years and $30,000 trying to prove that an affiliate of Warburg Pincus might be responsible for Mrs. Garcia's care. He has not named Formation or Warburg Pincus as defendants. A judge is expected to rule on some of his arguments this year.

Complex corporate structures have dissuaded scores of other lawyers from suing nursing homes.

About 70 percent of lawyers who once sued homes have stopped because the cases became too expensive or difficult, estimates Nathan P. Carter, a plaintiffs' lawyer in Florida.

"In one case, I had to sue 22 different companies," he said. "In another, I got a $400,000 verdict and ended up collecting only $25,000."

Regulators have also been stymied.

For instance, Florida's Agency for Health Care Administration has named Habana and 34 other homes owned by Formation and operated by affiliates of Warburg Pincus as among the state's worst in categories like "nutrition and hydration," "restraints and abuse" and "quality of care." Those homes have been individually cited for violations of safety codes, but there have been no chainwide investigations or fines, because regulators were unaware that all the facilities were owned and operated by a common group, said Molly McKinstry, bureau chief for long-term-care services at Florida's Agency for Health Care Administration.

And even when regulators do issue fines to investor-owned homes, they have found penalties difficult to collect.

"These companies leave the nursing home licensee with no assets, and so there is nothing to take," said Scott Johnson, special assistant attorney general of Mississippi.

Government authorities are also frequently unaware when nursing homes pay large fees to affiliates.

For example, Habana, operated by a Warburg Pincus affiliate, paid other Warburg Pincus affiliates an estimated $558,000 for management advice and other services last year, according to reports the home filed.

Government programs require nursing homes to reveal when they pay affiliates so that such disbursements can be scrutinized to make sure they are not artificially inflated.

However, complex corporate structures make such scrutiny difficult. Regulators did not know that so many of Habana's payments went to companies affiliated with Warburg Pincus.

"The government tries to make sure homes are paying a fair market value for things like rent and consulting and supplies," said John Villegas-Grubbs, a Medicaid expert who has developed payment systems for several states. "But when home owners pay themselves without revealing it, they can pad their bills. It's not feasible to expect regulators to catch that unless they have transparency on ownership structures."

Formation and Warburg Pincus both declined to discuss disclosure issues.

Groups lobbying to increase transparency at nursing homes say complicated corporate structures should be outlawed. One idea popular among organizations like the National Citizens' Coalition for Nursing Home Reform is requiring the company that owns a home's most valuable assets, its land and building, to manage it. That would put owners at risk if care declines.

But owners say that tying a home's property to its operation would make it impossible to operate in leased facilities, and exacerbate a growing nationwide nursing home shortage.

Moreover, investors say, they deserve credit for rebuilding an industry on the edge of widespread insolvency.

"Legal and regulatory costs were killing this industry," said Mr. Whitman, the Formation executive.

For instance, Beverly Enterprises, which also had a history of regulatory problems, sold Habana and the rest of its Florida centers to Formation because, it said at the time, of rising litigation costs. AON Risk Consultants, a research company, says the average cost of nursing home litigation in Florida during that period had increased 270 percent in five years.

"Lawyers were suing nursing homes because they knew the companies were worth billions of dollars, so we made the companies smaller and poorer, and the lawsuits have diminished," Mr. Whitman said. This year, another fund affiliated with Mr. Whitman and other investors acquired the nation's third-largest nursing home chain, Genesis HealthCare, for $1.5 billion.

If investors are barred from setting up complex structures, "this industry makes no economic sense," Mr. Whitman said. "If nursing home owners are forced to operate at a loss, the entire industry will disappear."

However, advocates for nursing home reforms say investors exaggerate the industry's precariousness. Last year, Formation sold Habana and 185 other facilities to General Electric for $1.4 billion. A prominent nursing home industry analyst, Steve Monroe, estimates that Formation's and its co-investors' gains from that sale were more than $500 million in just four years. Formation declined to comment on that figure.

Copyright 2007 The New York Times Company

Privacy Policy | Search | Corrections | RSS | First Look | Help | Contact Us | Work for Us | Site Map

The New York Times
nytimes.com

PRINTER-FRIENDLY FORMAT SPONSORED BY

October 24, 2007

Inquiries at Investor-Owned Nursing Homes

By CHARLES DUHIGG

Two Congressional committees announced yesterday that they would investigate business practices at nursing homes owned by private investment groups.

The scope of the inquiries by Representatives John D. Dingell of Michigan, chairman of the Energy and Commerce Committee, and Barney Frank of Massachusetts, head of the Financial Services Committee, are still being determined, but will probably include hearings and proposed legislation, a committee spokeswoman said.

The investigations are the latest scrutiny of private equity investments in nursing homes.

Last week, Senators Max Baucus, Democrat of Montana and chairman of the Finance Committee, and Charles E. Grassley, Republican of Iowa and its ranking minority member, sent letters to five private investment firms seeking information on their ownership and management of nursing home chains. The senators also asked the agency responsible for many payments to nursing homes, the Centers for Medicare and Medicaid Services, about its oversight of such homes.

This month, officials in five states expressed concern about the Carlyle Group's $6.3 billion acquisition of the nation's largest nursing home chain, HCR Manor Care. State legislators in Florida, Illinois, Pennsylvania, Michigan and Washington have asked regulators to investigate the acquisition by Carlyle, a private equity giant, or withhold approval pending greater scrutiny.

"There are serious concerns that private equity firms are reducing the care at nursing homes by decreasing the number of employees," Mr. Dingell said. "We've been made aware that nursing home residents are losing their ability to use lawsuits to fight poor care, and that people may be suffering."

A report last month in The New York Times said that private investment firms had bought thousands of nursing homes and often cut expenses and staff, sometimes below minimum legal requirements, to increase their profit. The article, which was cited by federal and state legislators as impetus for their investigations, described how investment groups used complicated corporate structures to avoid liability when residents suffered from neglect.

Representatives of the Carlyle Group and other private equity firms said their companies intended to cooperate with all inquiries. Carlyle said it was committed to maintaining high standards at the 552 Manor Care facilities after the deal closes, which is expected late this year.

The Manor Care deal was approved last week by shareholders but has drawn public protests, many coordinated by the Service Employees International Union, which represents some of Manor Care's workers.

"We've spent the last five years trying to improve long-term care for working Americans, and now private equity wants to come in and pocket as much as they can," the union's president, Andy Stern, said.

To counter such criticisms, Manor Care began sending letters to regulators and officials in the 32 states where its facilities are located, pledging to maintain staff levels and other quality standards. The company has also sent letters to residents and their families criticizing the article in The Times and the union's efforts. The mailings have said that the Carlyle Group does not intend to overhaul Manor Care in ways that make it harder for regulators to trace ownership.

But documents filed with Maryland regulators indicate that Carlyle plans to reorganize Manor Care to make each nursing home a stand-alone company, and to separate ownership of the homes' real estate and operations. Other private investment groups have used such structures to avoid liability and regulatory scrutiny.

In an interview, Manor Care's general counsel, Richard Parr, said the revamping was intended only to streamline operations and help the company achieve lower interest rates.

"It is very clear to regulators that Manor Care owns all of these entities, and that they are run by Manor Care employees, who are committed to delivering the best patient care possible," Mr. Parr said in an interview.

Lawyers who specialize in suing nursing homes are skeptical.

"Manor Care already fights tooth and nail in every lawsuit to say that the parent company should escape liability," said Nathan P. Carter, who has filed dozens of suits against Manor Care and other nursing home chains. "Every other chain that has this structure uses it to escape liability. I don't know why Manor Care would be any different."

The Congressional inquiries and hearings may lead to significant shifts within the nursing home industry.

"When Congress has examined nursing homes in the past, it's led to fundamental changes," said David Zimmerman, a professor at the University of Wisconsin and president of the Long Term Care Institute, a nonprofit group. "The government pays for a great deal of nursing home care. If they demand transparency on ownership and liability, they'll get it. Private equity groups have reasons to be concerned."

Copyright 2007 The New York Times Company

Privacy Policy | Search | Corrections | RSS | First Look | Help | Contact Us | Work for Us | Site Map

NATIONAL REAL ESTATE Investor

PRINT THIS
Powered by Clickability

A Much Rejuvenated Nursing Home Sector

By Joe Gose

Sep 1, 2006 12:00 PM

In the late 1990s, a double dose of trouble nearly sunk the nursing home industry. The federal government's Balanced Budget Act of 1997 gutted the Medicare reimbursement formula and cut into skilled nursing revenues. At the same time, plaintiff attorneys took aim at the industry for failing to roll patients over in bed often enough and providing other shoddy treatment, particularly in Florida and other states that possessed lax litigation laws.

The result: Longtime nursing home behemoths Integrated Health Services Inc., Mariner Post-Acute, Vencor and others sought bankruptcy or sold off their assets. But that's when private equity firm Formation Capital seized an opportunity. Between 2002 and 2006, the Alpharetta, Ga.-based investor spent $660 million to buy six nursing home portfolios comprising some 21,000 beds — about half in Florida and the remaining spread out over 20 other states — operated by six different companies.

Now, Formation Capital is cashing in on its investments. In June, Chicago-based GE Healthcare Financial Services agreed to buy Formation Capital's six portfolios for $1.4 billion. The deal, which includes 186 skilled nursing facilities, is scheduled to close sometime in the third quarter.

"Our industry went through a very tough time between 1999 and 2001, but now you have a very stable environment," says Arnold Whitman, CEO of Formation Capital. "There's a terrific investment opportunity in the skilled nursing sector, particularly where you have good operators that are in modern facilities in good locations."

Capital revival

Indeed, the GE Healthcare/Formation Capital deal signals a renewed interest of institutional investors in nursing homes, which, unlike the independent or assisted living sectors of the seniors housing industry, provide more hands-on care to short-term as well as long-term residents. During the first few years of this century, institutional investors avoided nursing homes even as they poured billions of dollars into other seniors housing assets.

But major transformations in the nursing home industry are attracting institutional investors, including a ground-breaking strategy shift in which nursing home operators are focusing on profitable short-term residents in need of physical rehabilitation.

The movement has spurred a debate among experts in the industry, with some suggesting seniors housing is bifurcating into distinct segments: residential facilities built for long-term renters who need little or no care versus skilled nursing centers; or "mini hospitals" that focus on short-stay patients who need more intense care.

But that argument ignores the continuing care retirement communities, which include acute care skilled nursing centers, assisted living facilities and independent living housing all in one campus, points out Michael Hargrave, sales and marketing director for the National Investment Center for the Seniors Housing & Care Industries (NIC). The Annapolis, Md.-based organization tracks business strategies and capital trends in the senior living industry.

The bottom line: Regardless of which model ultimately dominates the seniors housing industry, skilled nursing is once again attracting investors. Beyond the shift in strategy, capital providers say they like the government's consistent reimbursement policy, annual cash-on-cash returns in the low teens and stabilizing occupancies.

The average occupancy rate in skilled nursing facilities, for example, climbed one percentage point to 87.5% in the first quarter of this year from the last quarter of 2005, according to NIC (*see chart below*).

While average skilled nursing occupancy lags average occupancy in the independent living sector by five percentage points, the performance still illustrates improving nursing home fundamentals. In the fourth quarter of 2000, skilled nursing centers reported average occupancy of 82.4%.

Beyond increasing occupancy and dependable reimbursement policies, the outlook for skilled nursing homes appears favorable. The supply of new nursing homes is growing by 1% a year while the senior population is growing by 2% a year. In fact, some states are preventing new nursing home construction.

"It's a really great time for skilled nursing," says John Cobb, senior managing director for GE Healthcare's real estate finance team. "You have consistent performance, and the supply is actually going down rather than going up."

Tracking sales

Neither NIC nor other health care and real estate organizations track national property sales in the highly fragmented nursing home sector. Most experts say it's hard to separate real estate investors from regional operators who also own their properties.

In fact, while some companies such as Toledo, Ohio-based Health Care REIT typically invest in real estate and execute master leases with operators, Formation Capital invests in the nursing home companies who occupy the buildings as well as the properties themselves. In addition to receiving a rental income stream from operators, the private equity firm receives an even split of the company's profits.

What is clear is that lenders and other skilled nursing experts have noted an uptick in acquisition activity over the last six to nine months. NIC, which receives data from some of its members, suggests that average skilled nursing capitalization rates, which are a measure of a property's current yield, have stabilized at around 13%. That figure is down from 13.6% in late 2003.

Another measure of demand: Formation Capital paid $100,000 per bed for five skilled nursing facilities in the Dallas area, Whitman says, declining to provide more specifics. Although the facilities were relatively new, the price is more than double the average price per bed Formation Capital paid for the six portfolios earlier this decade.

"If you would have told me I was going to pay that price three years ago," he says, "I'd have said you're drinking or smoking something that I don't want."

Among other large transactions, San Francisco-based private equity investor Fillmore Capital earlier this year acquired Beverly Enterprises, a nursing home operator based in Fort Smith, Ark. The deal, which includes 346 skilled nursing facilities and some 75 other senior housing assets, was valued at $1.8 billion.

In July, Formation Capital joined with McLean, Va.-based JER Partners to pay $620 million for Tandem Health Care Inc. from New York private equity investor Behrman Capital. Tandem, based in Maitland, Fla., operates some 6,400 skilled nursing beds primarily in Ohio, Florida, Pennsylvania and Virginia.

"The skilled nursing industry generally sees waves of acquisition activity, and we're in one of those waves right now," confirms Jim Thompson, senior vice president of Horsham, Pa.-based Capmark Financial Group, formerly known as GMAC Commercial Holding Corp. Thompson declined to elaborate on the size of Capmark's nursing home portfolio.

Limited investment potential

Experts don't anticipate a deep well of activity, however. Complex federal and state regulations govern the industry, but laws and reimbursement policies differ dramatically from state to state, adding even more potential complexity to owning skilled nursing centers.

The aging stock of nursing homes also is a concern (*see sidebar, p. 77*). And, Cobb adds, nursing homes derive a majority of their revenue from the federal government. But as in the 1990s, the government can change its reimbursement policy. "That's difficult for a lot of institutional investors to understand," he says.

Still, the added risks have failed to dissuade some investors. In fact, the Formation Capital transaction marked GE Healthcare's first major equity investment in the seniors housing and care industries. Previously, the company had only provided floating-rate debt to health care real estate investors and had amassed a loan portfolio of $2.6 billion comprising medical office buildings, seniors housing properties and nursing homes.

But GE Healthcare added the private equity component after reassessing its products and receiving feedback from its clients when Cobb took the division's leadership reins three years ago. While the Formation Capital acquisition increases GE Healthcare's debt and equity property portfolio to $4 billion, the company anticipates announcing two more major seniors housing equity deals this fall, Cobb adds.

Profit equation

Skilled nursing's push for profitability certainly is behind the growing investor interest in the assets. How are operators doing it? Not only have nursing home companies adapted to the federal government's Medicare reimbursement formula that caused so much trauma in the late 1990s, but they're also trying to attract a larger percentage of Medicare and private-pay residents who require 30- to 60-day stays for physical rehabilitation or recovery. Those patients are much more lucrative than a nursing home's long-term residents, who typically receive Medicaid benefits, the state and federal program that primarily benefits the indigent.

Here's a likely scenario: An elderly patient who lives independently breaks his hip. He goes to the hospital and has surgery. While Medicare requires that patient to leave the hospital after a few days, he's still in no shape to return home. Medicare, however, will pay for an extended period in a nursing home, which is viewed as a lower-cost alternative to hospitals.

That's a major shift from the past, when long-term Medicaid residents generally generated the lion's share of a nursing home's revenues. But Medicaid typically provides nursing homes with a bare-bones reimbursement amount. In fact, experts say, many small nursing homes of 50 to 75 beds with a large percentage of Medicaid residents lose money. On average, Medicare reimbursements are two to three times the size of Medicaid reimbursements.

Case in point: Toledo, Ohio-based Manor Care, an operator of short-term post-acute and long-term care centers, received an average of $382 per day via Medicare reimbursements during the second quarter this year, compared with $151 per day in Medicaid and $228 a day in private reimbursements. Meanwhile, the company's quarter-over-quarter ratio, or "quality mix" of Medicare and private pay patients, grew two percentage points to 72% while occupancy grew one percentage point to 89%.

In a second quarter earnings call, Manor Care Chairman and CEO Paul Ormond told analysts that the company was positioned to take advantage of the growing number of short-term patients seeking lower-cost alternatives for acute care.

"Our company and our industry have done an awful lot to confirm over the past year that we are appropriate and capable providers for patients requiring much more intensive services and rehabilitation than we have traditionally cared for in the past in our skilled nursing centers," Ormond commented.

Although federal and state laws still generally require nursing homes to take Medicaid patients, skilled nursing operators usually find success in facilities with an average of about 120 beds. Combined with a decent quality mix, that size allows operators to still take residents on Medicaid, which can help pay for an operator's fixed costs, Whitman says.

The bottom line: The model's success will attract capital to nursing homes going forward, he predicts. "This business has changed from being a Medicaid-driven industry for the indigent who end up in nursing homes in their last years, to one that's providing a lot of care and service in a low-cost environment," Whitman concludes. "That's a dramatic and opportunistic evolution."

Joe Gose is a Kansas City-based reporter.

Ungraceful aging of nursing home supply

The aging stock of nursing homes is a chief concern among healthcare experts, who have only recently witnessed institutional capital return to the industry after a several-year hiatus. In the top 30 metropolitan markets, the median age of nursing homes is 29 years and almost 33% of skilled nursing properties need upgrades, according to the National Investment Center for the Senior Housing & Care Industries, an organization based in Annapolis, Md., that tracks investment trends in the industry.

For nursing home operators, presenting a modern facility to potential residents is a critical marketing component, especially as a growing number of skilled nursing centers compete for profitable short-term residents in need of physical therapy.

"If you're taking your mom around to different nursing homes for post-surgical care, the quality of care matters a great deal, but so does the physical appearance," says Michael Monticello, senior vice president of commercial banking for Chicago-based LaSalle Bank. "That type of resident can often make a decision between five different nursing homes in their community."

As a result, many nursing home operators and owners have renovated their buildings to include rehabilitation centers, private rooms, private baths and other amenities over the last several years. Many are still pursuing renovations to add beds or expand therapy centers.

During the second quarter of this year, Toledo, Ohio-based Manor Care spent some $40 million to expand 36 skilled nursing centers — most of which focused on physical rehab space additions — and to build five new skilled nursing homes. In the first quarter, Toledo-based Health Care REIT acquired seven skilled nursing properties totaling 766 beds in Ohio and is conducting a major rehab of all the assets. The total capital committed for the purchase and renovations: $63 million.

Some skilled nursing facilities are simply obsolete, however, and cannot be rehabbed cost-effectively. But a wholesale replacement of such buildings is hardly on the horizon: Many states require nursing homes to acquire a "certificate of need" before any new beds can be added to the existing stock, restricting new development. And some states have placed a moratorium on the issuance of certificates of need.

"The aging stock is a huge and very important issue," says Arnold Whitman, CEO of Formation Capital. "The overall population is dated and is in need of repair or razing, one or the other."
— **Joe Gose**

Want to use this article? Click here for options!
© 2007 Penton Media, Inc.

Find this article at:
http://www.nreionline.com/mag/real_estate_rejuvenated_nursing_home/index.html

☐ Check the box to include the list of links referenced in the article.

© 2008 Penton Media, Inc. All rights reserved.

U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

NURSING HOME DIVESTITURE AND CORPORATE RESTRUCTURING:

FINAL REPORT

December 2006

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared under contract #HHS-100-03-0033 between HHS's ASPE/DALTCP and the MEDSTAT Group. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, Susan Polniaszek, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Susan.Polniaszek@hhs.gov.

NURSING HOME DIVESTITURE AND CORPORATE RESTRUCTURING: Final Report

David Stevenson, Ph.D.
David Grabowski, Ph.D.
Laurie Coots, B.A.

Harvard Medical School

December 2006

Prepared for
Office of Disability, Aging and Long-Term Care Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
Contract #HHS-100-03-0033

The opinions and views expressed in this report are those of the authors. They do not necessarily reflect the views of the Department of Health and Human Services, the contractor or any other funding organization.

TABLE OF CONTENTS

ABSTRACT iii

INTRODUCTION AND PROJECT OVERVIEW 1

BACKGROUND/SUMMARY OF LITERATURE REVIEW 3
- The Rise of the Nursing Home Industry 3
- Changes in Reimbursement Policy 4
- Bankruptcies of the Major Chains 5
- Re-emergence of the Industry and New Challenges 5
- The Nursing Home Industry Today 7
- Summary 7

DATA ANALYSES 8
- Introduction 8
- Data and Methods 8
- Results 9

POLICY IMPLICATIONS AND THE NEED FOR FUTURE RESEARCH 12

REFERENCES 16

LIST OF FIGURES AND TABLES

FIGURE 1: Number of Nursing Home Facilities and Beds, United States, 1993-2004 18

FIGURE 2: Percent Chain Nursing Home Providers, United States, 1993-2004 19

FIGURE 3: Nursing Home Occupancy Rates by Chain and Non-Chain Facilities, 1993-2004 20

FIGURE 4: Nursing Home Occupancy Rates by Chain and Year, 1993-2004 21

FIGURE 5: Percent Medicare Residents by Chain and Year, 1993-2004 22

FIGURE 6: Percent Medicaid Residents by Chain and Year, 1993-2004 23

FIGURE 7: Percent Other Pay Residents by Chain and Year, 1993-2004 24

TABLE 1: Percent of Chain Nursing Homes by Year 24

TABLE 2: Total Number of Facilities and Beds by Chain and Year, 1993-2004 25

TABLE 3: Number of States in which Chains Operate by Year, 1993-2004 26

TABLE 4: Number of Chain-Operated Facilities in Florida by Chain and Year 27

TABLE 5: Number of Chain-Operated Facilities in Texas by Chain and Year 28

ABSTRACT

Over the past two decades, the nursing home industry has experienced changes in the financial, regulatory, and competitive environments. Nursing homes have been greatly impacted by federal and state policies, such as the regulatory reforms of the Omnibus Budget Reconciliation Act of 1987 and the payment reforms of the Balanced Budget Act of 1997. Occupancy rates have fallen in the context of shortened lengths of stay for residents and increased competition from assisted living facilities and other home and community-based care. State Medicaid payment rates vary substantially across states and have gone through periods of relative generosity and parsimony. Nursing home malpractice litigation has increased causing an increase in overall operating costs, especially in a handful of states.

Responding to these and other policy and market factors, the nation's largest chains have undergone periods of considerable expansion, contraction, and retrenchment. The role of chain providers, which represent more than half of all facilities, is significant in the nursing home industry, and a recent study by Medstat found that many chains have reacted to recent trends by divesting ownership in certain markets and pursuing other types of corporate restructuring. To investigate these issues further, the Office of the Assistant Secretary of Planning and Evaluation contracted with Medstat and Harvard Medical School to study recent trends in nursing home divestiture and corporate restructuring of the nation's largest nursing home chains.

After a review of the literature and analyses of On-line Survey, Certification, and Reporting (OSCAR) data, the final report describes the trends in nursing home ownership by national chains over the past decade and discusses policy implications. The literature review identified the policy and market incentives that led the nursing home industry and especially national chains to expand substantially. The generous cost-based reimbursement policies attracted investment in the industry and encouraged substantial merger and acquisition activities. The review highlighted several challenges that followed when market conditions were less favorable, leading highly leveraged chains to bankruptcy, divestiture, and corporate restructuring.

The outcome of these challenges is a national chain sector that is smaller and differently focused than it was ten years ago. Government financing remains vital, with corporate structure also heavily influenced by factors such as litigation, state reimbursement climates, and geographic considerations. The industry today maintains a moderately healthy capital structure. The industry's re-emergence and relatively better financial condition are attributed to more rational portfolios of nursing home ownership, improved access to capital, and improved Medicare reimbursement.

Guided by the literature review, we set out to describe the nursing home industry and document ownership trends over the last decade. In particular, we analyzed OSCAR data from 1993-2004 to gain a descriptive look at the nursing home industry over time. As with the literature review, our focus was on the characteristics and

activities of the nation's largest nursing home chain providers. Analyses of these data nationally, within states, and across specific chains, revealed several broad themes. Nationally, nursing home chains have consistently owned or operated half of all facilities. Importantly, these aggregate numbers masked important state and chain-specific trends.

Analysis of large national chains indicated a trend toward consolidation in the industry, exemplified by smaller chains operating in fewer states and, in some states, emergent regional chains replacing the national chains. For example, our analyses documented the strategic withdrawal of national chains from certain key states like Florida and Texas where malpractice litigation has been particularly acute. In sum, these analyses indicated that the nursing home industry over the past decade was a dynamic one marked by expansions, bankruptcies, divestitures and corporative restructuring.

The analyses highlighted several issues for policymakers, stakeholders, and researchers, including areas where further research is needed. Importantly, the analyses show that there is substantial variation across national chain providers in the strategies by which they navigate policy and market conditions. Thus, in researching nursing home chains in comparison to the rest of the nursing home industry, it is important to focus beyond the dichotomous "Yes/No" of whether a facility is part of a chain and to investigate more about the specific characteristics and practices of the parent company.

Moreover, some of the restructuring and financing trends that were identified have unclear implications for the quality of care received by nursing home residents (e.g., the increased role of Real Estate Investment Trusts in the senior housing market). Although further research into some topics is made difficult by the lack of comprehensive data on facility ownership, further analytic work is ultimately needed to investigate these trends more thoroughly and to analyze whether they have had any impact on nursing home residents' quality of care.

INTRODUCTION AND PROJECT OVERVIEW

Over the past two decades, nursing homes have experienced changes in the financial, regulatory, and competitive environments that have influenced the manner in which they do business. Many of these shifts resulted from government policy changes and demonstrate the extent to which the nursing home industry and government are intertwined. The Omnibus Budget Reconciliation Act (OBRA) of 1987 established extensive operating guidelines that are enforced by the Centers for Medicare and Medicaid Services (CMS) through state survey agencies. OBRA guidelines and regulations enacted subsequently shape the manner in which nursing homes provide care, as well as the penalties they face for non-compliance. Nursing homes depend on Medicaid and Medicare for the majority of their financing (66 percent and 13 percent of nursing home residents relied on Medicaid and Medicare in 2004, respectively). Thus, changes in state and federal regulations and reimbursement policies can have a tremendous impact on the nursing home industry. A key example that will be discussed below is the impact of the Balanced Budget Act (BBA) of 1997 and the shift to prospective payment for skilled nursing facility (SNF) care under Medicare.

Intertwined with public policies at the state and federal levels, other environmental pressures have affected nursing homes in recent years. The growth of assisted living and the home and community-based care sector generally has provided increased competition to nursing homes, especially for private paying residents with lower acuity levels. At the same time, nursing homes have cared for higher acuity residents who are often admitted from hospitals for shorter lengths of time. Reflecting these trends, nursing home occupancy rates have fallen substantially over the last few decades.[1] Further pressures have been felt due to the emergence of nursing home litigation and the increased costs of general and professional liability insurance. Importantly, these costs have been especially high in a small number of states, such as Florida and Texas.[2,3,4,5] Underlying these market and policy factors are broader demographic shifts. Although the United States population is growing older, the need for long-term care services has been less than expected due to declining disability rates.[6]

Responding to these trends, the role of multi-facility providers in the nursing home industry has changed in recent years. For-profit, chain providers typically have had a large role in the nursing home industry, with more than half of all nursing homes being part of a chain and almost two-thirds of the industry operating on a for-profit basis. These aggregate figures have been relatively stable over time, but they mask substantial changes among the chains and in specific states. In particular, responding to policy, market, and other factors, the nation's largest chains have undergone periods of considerable expansion, contraction, and retrenchment. Little has been written about these changes and their implications for nursing home care. Seeking to fill this gap, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with MedStat and Harvard Medical School to study the role of divestiture and corporate restructuring of nursing homes. The overall objectives of this project were: (1) to describe the extent to which corporate restructuring has occurred among nursing home

chains and to identify the states or markets in which this has occurred; (2) to describe factors that have influenced organizational restructuring and divestiture strategies; and (3) to highlight unanswered questions for future research.

The current work builds on previous research also funded by ASPE. Specifically, a recent ASPE-funded study of the nursing home liability insurance market conducted by MedStat found that many nursing homes chains have been reacting to environmental changes by divesting ownership of facilities in certain markets and pursuing other types of corporate restructuring. The tasks of the current project were to review the current literature on the topic and to pursue related analytic work using On-Line Survey, Certification, and Reporting (OSCAR) data. Because of the dominance of the national chains, the study emphasizes their activity in particular. The Final Report, presented here, summarizes the literature review and the analytic findings and concludes with a discussion of the policy implications and areas for future research.

BACKGROUND/SUMMARY OF LITERATURE REVIEW

To provide background information and inform the OSCAR analyses, a key component of the project was the literature review, completed in May 2006. Conducting a review of literature on nursing home divestiture and corporate restructuring presented some challenges. The literature in peer-reviewed and academic journals on the topic is limited; thus, we included additional resources such as business reports, professional and trade journals, newspaper articles, briefings, and conference proceedings. These sources were supplemented by interviews with key stakeholders in the nursing home industry and in the investment community.

The literature review focused on the nursing home industry over the past two decades with a focus on corporate restructuring and divestiture practices among the largest national chains.[a] Relevant topics included the expansion of the nursing home industry in the 1990s, reimbursement policies and related changes over the study period, widespread bankruptcies among the major national chains, and a discussion of the industry today and the challenges it faces.

The Rise of the Nursing Home Industry

Until the mid 1980s, post-acute care accounted for only a small percentage of total Medicare expenditures, and Medicare dollars were a relatively small portion of nursing facility revenues. The implementation of Medicare's acute care hospital prospective payment system (PPS) in 1984, however, created an incentive for hospitals to discharge patients more quickly, leading to a higher acuity case-mix for nursing homes and substantial increases in Medicare's spending for SNF care.[7] At the same time, Medicare's generous cost-based reimbursement provided nursing facilities with relatively generous payments compared to traditional Medicaid-financed nursing home care.[8] Moreover, Medicare's cost-based payment to SNFs extended to ancillary nursing home services such as rehabilitation therapies and pharmacy services. Under such incentives, nursing homes found they could maximize profits by admitting more Medicare patients with greater ancillary service needs and, often, by increasing their emphasis on ancillary service provision.

Combined with expectations for greater service demand because of population aging, these generous reimbursement policies attracted investments in the nursing home industry by national corporations and Wall Street. For-profit nursing home chains

[a] For the purposes of this study, we define corporate restructuring as the reorganization of corporate assets to achieve an organization's strategic objectives. Divestiture is a subcomponent of restructuring and represents the targeted sale of facilities in particular geographic or market areas. Divestiture might be initiated in response to an unfavorable reimbursement or litigation climate in a state or market or a response to other geographic specific factors that affect a company's bottom line.

issued public stock offerings and secured generous lines of debt.[9] Other creative financing strategies also were employed such as monetizing assets by selling facilities and land to Real Estate Investment Trusts (REITs) that would then lease the facilities back to the operators. By monetizing assets, companies could procure additional capital without more debt appearing on balance sheets.

Over the 1990s, nursing home operators put their supply of capital to use by expanding operations through acquisitions of other nursing homes and by developing or acquiring ancillary service capacity and complimentary lines of business. Conventional wisdom at the time held that larger nursing home chains would benefit from economies of scale through minimizing overhead costs and gaining negotiating clout with vendors, managed care plans, and the government.[10] Since certificate of need laws largely inhibited the construction of new nursing home facilities,[11] the simplest way to get bigger was sometimes through acquisitions. Rather than using cash from operations to make these purchases, companies increasingly relied on borrowing. As such, nursing home corporations, Wall Street, lenders, and REITs were placing bets that favorable industry trends would continue.

Changes in Reimbursement Policy

After experiencing phenomenal growth during the 1990s, the industry faced several major challenges, most notably the implementation of Medicare's PPS for SNFs. In particular, Congress enacted provisions in the 1997 BBA to address the rapid increase in post-acute care expenditures, mandating PPS for SNFs and other Medicare-financed post-acute care. Beginning July 1998 under the PPS, Medicare paid nursing homes a preset, case-mix adjusted per-diem payment that covered all costs, including ancillary services. Beyond the SNF PPS, BBA provisions also included caps on the amount of rehabilitation therapy services that Medicare would pay for in a calendar year, further squeezing companies that owned rehabilitation subsidiaries. Importantly, however, these caps were in place for only short periods of time because of two subsequent moratoria on their enactment.

The impact of the BBA on the nursing home industry was substantial. Implementing PPS required costly administrative changes by corporations at a time when the chains were handling other integration issues stemming from substantial merger and acquisition activities. The payment changes led several publicly traded companies to report disappointing earnings in the period immediately following implementation.[12,13] Beyond the initial transition period, the financial impact of the payment changes was greater than some anticipated. The Congressional Budget Office (CBO) initially estimated that the law would cut payments by $9.5 billion over five years; one year after the law went into effect, CBO revised its estimate to almost twice that amount.[14]

Bankruptcies of the Major Chains

Many nursing home operators with large financial exposure to Medicare rapidly became distressed. Cuts in Medicare reimbursement were a major reason for the financial troubles facing highly leveraged nursing home chains, and other market forces negatively impacted the industry as well. The Office of the Inspector General and the Justice Department turned their attention to the nursing home industry, exercising increased scrutiny over billing, cost reporting, and patient care practices. Additionally, because of state fiscal crises, Medicaid programs began looking for ways to reduce costs including reducing the rate of increase in nursing home payments. At the same time, the nursing home industry started to face stronger competition from other provider settings, including the assisted living industry.

The confluence of these negative forces proved too much for many providers. Declines in cash flow led almost all of the publicly traded companies to default on their loans, and the distressed companies reportedly had few avenues by which to reverse the trend. Although some companies were able to sell off assets, at greatly reduced rates, bankruptcy was the final option for others. By the fall of 1999, a number of publicly traded companies began to seek protection under Chapter 11 of the bankruptcy code. By 2000, five of the seven largest nursing home operators were in bankruptcy protection (Beverly and Manor Care remained solvent). In each case, the companies attributed this outcome to cuts in Medicare as the primary cause;[15] a General Accounting Office report at the time, however, noted that the companies brought some of the repercussions on themselves.[16]

Re-emergence of the Industry and New Challenges

The companies who sought Chapter 11 protection reorganized during the 2000-2003 period by focusing on core operations such as management and cost control. The nursing home industry also lobbied Congress successfully to restore some funding cuts. The Balanced Budget Refinement Act of 1999 and the Benefits Improvement Act of 2000 improved reimbursement by establishing temporary payment increases from Medicare. Most of these increased payment levels "cliffed" at the end of 2002, causing some financial stress within the industry. The remaining temporary payment increases were eliminated in 2006 when CMS refined the payment classification system.

Still, even with improved reimbursement from Medicare, most national chains opted to divest and restructure operations. Strikingly, some national chains emerged as smaller, differently focused companies. According to analysts, divestitures typically were driven by three factors, including high malpractice expenses, poor Medicaid reimbursement, and geographic dissonance with other company holdings, all of which could lead particular facilities to under-perform financially.

Nursing home litigation grew dramatically after 2000 and became recognized as one of the fastest growing areas of health care litigation,[5] leading to substantially higher

liability insurance premiums and overall increased practice costs. To reduce medical malpractice exposure, publicly traded companies began to divest their assets and exit from states with the highest risk.

In January 2001, for example, Beverly announced that it was exiting Florida and other states with "higher-than-average malpractice expenses."[17] Over a six-month period in 2003, Beverly divested 73 facilities that accounted for 18 percent of the company's revenues but 34 percent of its malpractice expense.[17] Other companies followed the same strategy. Genesis, Kindred, Extendicare, and Mariner all exited Florida, and Manor Care has divested some of its assets in the state. Companies also partially or completely exited other states with high malpractice insurance rates, such as Texas, California, Mississippi, Arkansas, and Alabama.[17]

Although the divestiture trends can be explained partly by malpractice concerns, there were other considerations. Medicaid reimbursement varies considerably across states, and the nursing home industry posits that these payments fall short of costs in some markets.[18] Reflecting these factors, some publicly traded nursing home operators shed assets in states with lower Medicaid payment. Between 1999 and 2003, for example, publicly traded companies reportedly divested more than 25 percent of their holdings in states with highly unprofitable Medicaid nursing home reimbursement levels, in states such as Arizona, Delaware, and Massachusetts.[17,18]

Finally, companies re-structured assets to concentrate operations in a smaller number of states, a principle some term "regional dominance." In particular, operators divested holdings in states where they did not have much presence, reflecting a more conservative strategic approach. Companies can obtain a greater understanding of rules and regulations in a particular state and possibly a greater influence over them as well. Strong regional concentration allows for economies of scale in purchasing and overhead and could enable companies to manage admissions across facilities.

The publicly traded companies sold many facilities to smaller, regional operators who found acquisition prices for these assets attractive. In addition, the smaller companies often had a strong regional presence, so the additional purchases enhanced their geographic strength. For the larger chains, divestitures helped improve their balance sheets and shed under-performing facilities.

As companies emerged from bankruptcy protection, they also benefited from the return of more generous government reimbursement levels. Ultimately, the combination of more rational asset portfolios, greater concentration within regional markets, and better Medicare payments allowed nursing homes to improve their financial condition.

The Nursing Home Industry Today

Today, the nursing home industry maintains a moderately healthy capital structure and strong earnings, according to Wall Street analysts and long-term care executives. While most nursing home companies still generate the majority of their revenues from their nursing home business, some focus has been shifted toward faster growing complimentary businesses such as hospice care, assisted living, and home health. Some divestiture proceeds have gone toward purchasing complimentary businesses, but much has been used to decrease companies' debt levels. Publicly traded companies reduced their aggregate debt by nearly $1 billion, or approximately 45 percent, from 2000 to 2004,[19] helping the industry's overall financial condition.

Although some companies improved their balance sheets, others still have faced difficulty securing financing from the capital markets over the past five years. Reflecting these difficulties, alternative financing strategies, such as selling real estate assets to REITs, continued to be employed. The degree to which companies rely on REITs varies considerably. In 2004, Manor Care owned 94 percent of its facilities whereas Kindred owned only 3 percent.[17] A related trend is that private equity groups recently have purchased nursing homes, in part, to divide the operations from the real estate. Integrated Health Services, Mariner Health Care, and, most recently, Beverly, are examples where equity groups purchased chains with the intention of separating the real estate and operations with the goals of limiting liability and enhancing profitability. While REITs have grown in prominence, the implications for care delivery and quality are unclear.

Summary

In summary, the nursing home industry has gone through a tumultuous two decades. Policy, demographic, and market incentives led the industry to expand substantially in the years leading up to the BBA of 1997. At that time, many nursing home chains were highly leveraged in anticipation of favorable market conditions that ultimately were not sustained. Our review found that the subsequent bankruptcies of major nursing home chains and the reorganization of the industry have resulted in multi-facility companies that are smaller and differently focused than they were ten years ago. Medicare is still vitally important to these companies, but their corporate structure is also heavily influenced by other factors such as litigation, state reimbursement climates, and geographic considerations.

DATA ANALYSES

Introduction

Conclusions and themes from the literature review guided the analytic component of this study. The trends identified through the review indicated areas where more in-depth and detailed analyses were warranted in order to quantify these trends nationally and across the major national chains. In particular, we sought to characterize the expansion, contraction, and reorganization of the nation's largest nursing home chains, in some cases relative to the rest of the nursing home industry. In the analyses below, we describe aggregate trends across specific chains and states, chain-specific occupancy rates and payer-mix, and the targeted exit of chains from selected states.

Data and Methods

To analyze trends in the nursing home industry and document ownership trends over the last decade, we analyzed data from the OSCAR system. OSCAR is a longitudinal database containing survey and certification information for providers that are Medicaid and Medicare certified. Nursing homes submit facility, resident, and staffing information. Deficiency data are based on findings from state survey agencies and entered by these agencies when nursing homes do not meet federal regulatory standards. OSCAR data are collected through regular surveys every 9-15 months, and these data are submitted to CMS. Data from the years of 1993-2004 were obtained for this project; these data were cleaned and merged to pursue the analyses. Facilities included in OSCAR data account for almost 96 percent of all nursing homes nationwide, and provide a comprehensive snapshot of the industry as a whole. Facilities not certified by Medicare and Medicaid (e.g., private pay facilities) are not included in the OSCAR dataset.

To create the longitudinal analytic file, we merged OSCAR data from 1993-2004 for each facility. Specific variables, such as the address text fields, were cleaned to ensure the tracking of individual facilities over time. The final longitudinal analytic file contained a total of 197,787 records, where each record represents one facility survey observation, and approximately 800 variables.

We grouped facilities into particular multi-facility organizations (or "chains"), assigning numeric identifiers based on the Name of Multi-Facility Organization free-text field (item F14 of CMS form 671). OSCAR defines a multi-facility organization as an organization that owns two or more facilities. The owner may be an individual or a corporation and this definition includes leasing of facilities by corporate chains. Of the 197,787 OSCAR records, 53 percent (n=104,495) had multi-facility ownership indicated; we coded 42 percent (n=43,747) of these records into 84 of the largest national chains.

Because the CMS-issued provider identification numbers used in the OSCAR do not uniquely identify facilities (which we define as a specific "bricks and mortar" location), unique facility identifiers were created based on a combination of variables, including the CMS-issued provider identification numbers, address fields, survey dates, and facility size. A total of 25,193 unique facility identifiers were created and added to the analytic file. These facility identifiers were used to generate annual nursing home counts for the analysis in combination with survey date. Because OSCAR surveys are required every 9-15 months, an algorithm was needed to ensure that the most accurate estimates were obtained. The average facility is surveyed every 12 months (mean=373 days), making it possible that an operating nursing home may not have been surveyed or that it was surveyed more than once during a particular calendar year. To address these issues in our facility counts, we added a two-year window around each survey date to count facilities while systematically addressing duplicates and closed facilities. Unadjusted counts for 2003 and 2004 are tentative because they do not remove facilities that may have closed; it is possible that these data are incomplete and that additional data from these years will be included in the 2005 data file. Where noted, we adjust the national number of facilities in 2003 and 2004 based on previous closure rates observed in the data.

Results

Description of Nursing Home Industry and Chain Presence. Figure 1 provides an overview of the nursing home industry at the national level from 1993-2004. Industry bed capacity increased from 1,658,420 beds nationally (15,450 facilities) in 1993 to peak in 1998 with 1,861,925 beds (17,355 facilities), before declining slightly to 1,734,735 beds (15,915 facilities) in 2004. Focusing on more recent years, the relative decline from the industry peak in 1998 to 2004 was a 7 percent and 8 percent decline in beds and facilities, respectively. Across the study years, there were approximately 16,700 nursing homes and a corresponding 1.8 million nursing home beds on average. Not surprisingly, states differed considerably in the size of their nursing home industries. Facilities in California, Texas, and Ohio alone accounted for almost 23 percent of all facilities nationwide in 2004 (not shown).

Figure 2 shows the percent of chain providers over the study period. Similar to bed capacity, the percent of facilities operating as chains increased from its 1993 level of 49 percent to peak in 2001 at 56 percent, before declining slightly in 2004 to 52 percent. Although this percentage varied across states, ranging from 10-73 percent in 2004, it was generally in the 40-60 percent range for states across the study years (not shown). Table 1 displays these data in tabular form and also includes the proportion of chain facilities owned by the "major" nursing home chains. The proportion of chain facilities owned by the largest (or "top") five and ten chains averaged 16 percent and 24 percent, respectively, over the study period.

Table 2 provides an introduction to the major chains by highlighting the top ten nursing home chains (based on number of facilities) in any study year, for a total of 20

chains. Importantly, many of the chains listed have undergone organizational changes such as mergers, bankruptcies and divestitures over the study period, some of which are detailed in the text-box below.

Summary of Mergers, Bankruptcies, and Purchases (1993-2004)

- HCR merges with Manor Care in 1998.
- Paragon and Mariner merged in 1998 and were named the Mariner Post Acute Network.
- Hillhaven facilities were acquired by Vencor.
- Vencor filed for bankruptcy in 1999 and re-emerged as Kindred in March 2001.
- In 1994, Columbia and HCA merged into Columbia/HCA.
- Horizon/CMS facilities were purchased by Integrated Health Services.
- Integrated Health Services went bankrupt and their facilities were taken over by Trans Healthcare in 2000.
- Sun Healthcare went bankrupt in 1999 and emerged in 2002.
- Genesis went bankrupt in 2000 and emerged in 2001.
- Mariner went bankrupt in 2000 and later merged with National Senior Care in 2004.

Beverly Enterprises was consistently ranked as the largest chain on both number of facilities and beds across study years, despite having less than half as many beds in 2004 as in 1993. The table notes the bankruptcy of Vencor and its re-emergence as Kindred. Also included is the 2001 merger of the Health Care and Retirement Corporation (HCR) with Manor Care, which has become one of the largest nursing home chains in the country. Finally, the table notes the exit of three major chains, Hillhaven, Horizon/CMS Health Care, and Unicare Health Facilities. Although trends in size varied across companies, several chains have become smaller in recent years, including Beverly, Kindred, Mariner, Genesis, and, perhaps most strikingly, Sun Healthcare.

Figure 3 displays national occupancy rates, illustrating differences by chain and non-chain ownership. Defined as the number of total residents divided by the number total number of beds (both of which are facility-reported in OSCAR), occupancy rates have decreased between 1993 and 2004. In 1993, the rate was 86 percent which decreased to 82 percent in 1997 and has remained relatively stable since then. Differences in occupancy rates among the national chains are illustrated in Figure 4. The largest nursing home chains generally have maintained higher occupancy rates than the national averages with the exception of HCR Manor Care which -- until more recent years -- had lower than average occupancy rates.

As shown in Figure 5, Figure 6 and Figure 7, providers vary in the extent to which their residents rely on different payer sources. In our most recent year of data (2004), the reliance on Medicare ranges from 7-23 percent; the reliance on Medicaid ranges from 52-71 percent; and the reliance on private/other sources ranges from 16-35 percent. Several of the largest chains, including Beverly, Genesis, Vencor/Kindred, and Sun, show similar trends over time in the proportion of residents across the respective payer categories. Among these larger providers, Manor Care and Good Samaritan are somewhat distinctive in their payer-mix. Both chains have relatively high proportions of residents relying on private/other payers, and relatively low proportions of residents

relying on Medicaid. These two providers diverge in their reliance on Medicare, with Manor Care's reliance relatively high and Good Samaritan's relatively low. As a whole, with some exceptions, the larger chains exhibit greater reliance on Medicare and lesser reliance on Medicaid and other payer sources than the rest of the nursing home industry.

Analyses of State Trends. Table 3 summarizes the number of states in which each chain operates across study years. As detailed, some chains -- such as Beverly, Genesis, and Sun Healthcare -- were more aggressive in contracting their operations geographically than others. Beverly went from a high of 708 facilities in 36 states in 1995 to 377 facilities in 27 states in 2004. Even more striking, between 2000 and 2004, Sun Health went from 272 facilities in 25 states to 95 facilities in 14 states in 2004. Based on our previous analyses, Florida and Texas are two states of particular interest because of the reported departures by many national chains responding to the litigation climates. Table 4 and Table 5 list chain providers that owned or operated at least ten facilities in Florida and Texas during the study period.

Of the national chains still operating in 2004, Beverly, Genesis, Kindred (formerly Vencor), Extendicare, and Mariner all exited Florida (Table 4). During the period when these chains were exiting the Florida market, some other chains emerged. Specifically, the Delta Health Group, Sea Crest Health Care Management, and Tandem Health Care increased their numbers of facilities during this period. As of 2002, Delta operated the majority of its 267 facilities in Florida, Sea Crest operated its 131 facilities exclusively in Florida, and Tandem operated many of its 233 facilities in Florida (also operating in New Jersey, Ohio, Pennsylvania, Tennessee, and Virginia).

As shown in Table 5, Texas experienced similar trends to Florida in recent years, with some national chains exiting the state. Among currently operating chains, exiting companies included Beverly, Extendicare, Sun, and Integrated Health Services. During this same period, Daybreak Healthcare, Senior Living Properties, and Mariner Health Care increased their number of facilities in Texas. As of 2002, Daybreak operated its 183 facilities exclusively in Texas, and Senior Living Properties operated its 301 facilities across Illinois and Texas. Mariner operates its 258 facilities across several states.

POLICY IMPLICATIONS AND THE NEED FOR FUTURE RESEARCH

Analyses of OSCAR data provide a descriptive look at the nursing home industry. In particular, these data provide the ability to chart the trends in acquisitions and divestitures of nursing facilities by national chains over time, as was the focus of this study. Analyses of these data nationally, within states, and across specific chains, revealed several broad themes. Nationally, nursing home chains have consistently owned or operated half of all facilities. However, these aggregate numbers mask state and chain-specific trends of importance.

Analysis of large national chains indicated a current trend toward consolidation in the industry, exemplified by smaller chains operating in fewer states and, in some states, emergent regional chains replacing the national chains. The strategic withdrawal from certain key states suggests a benefit to geographic concentration and a movement away from certain states in particular. Occupancy rates have declined across the nursing home industry, reflecting increased competition from nursing home alternatives such as assisted living, reduced lengths of stay among current residents, and lower than expected demand for services resulting from declining disability rates. The larger chains vary in the extent to which their residents rely on different payer sources; however, most share a trend toward greater reliance on Medicare and post-acute care. These analyses indicate that the nursing home industry over the past 12 years was a dynamic one marked by extensive acquisitions, mergers, bankruptcies, and divestitures.

These descriptive analyses highlight several issues for policymakers, stakeholders, and researchers, including areas where future research is needed. Importantly, a variety of factors extrinsic to demographic trends influence the demand and utilization of nursing home care. The findings show that federal and state policy and market conditions greatly impact the behavior and corporate structure of large nursing home chains. Not only did federal payment reforms of the late 1990s impact the overall health of the national chains, state level factors such as litigation and reimbursement impacted the manner in which organizations emerged from bankruptcies and remained solvent during challenging economic times.

As organizations move forward, it is difficult to overstate the importance of Medicare and Medicaid payment policies. Payment policies not only impact providers' profitability, but also the composition of companies themselves. For instance, many of the nursing home closures that happened following the BBA were hospital-based facilities with smaller than average bed size and higher acuity.[20] Although providers learned many lessons from the impact of SNF PPS almost a decade ago, many of the largest chain providers have a considerable, although differently focused, investment in these services today. It should be noted that the impact of Medicare payments policies on nursing home chains extends beyond SNF payments. Home health, rehabilitation, long-term care hospital, and hospice payments all can impact nursing homes, either

directly or indirectly. Many of the larger nursing home chains have significant investments in these other services. For instance, Manor Care has a sizeable hospice operation, and Kindred is heavily invested in long-term care hospitals. In addition, as nursing home companies become more geographically concentrated, the impact of specific states' Medicaid policies will grow in magnitude. Although general trends have pointed to Medicaid rate stability in recent years, states can vary considerably in their payment and related policies.[21] Some states, for instance, are taking a lead in promoting Medicaid-financed alternatives to nursing home care and transitioning individuals from these settings.[20]

Overall, the emphasis of nursing home chains on specific geographic markets, ancillary/complementary services, and payers sources could signify one of two things. The new business model for chains may be to concentrate their operations in specific market niches (e.g., geographic areas, product types, etc.) to develop competitive advantages in their areas of focus. Alternately, the business models now employed by chains could reflect different "bets", the outcomes of which will become more apparent over time. For example, providers such as Manor Care are focusing on Medicare post-acute care stays and on increasing their development of hospice services, demonstrating a willingness to trade increased resident turnover (and potentially lower occupancy rates) for higher profitability per resident day.

One important trend influencing nursing home corporate strategy is the spread of litigation against nursing homes. As noted above, nursing home litigation has grown substantially over the last decade, especially in states such as Florida and Texas. The financial impact of this litigation is substantial, with one study estimating the overall magnitude of litigation in Florida and Texas in 2001 to be 23 percent and 15 percent of annual nursing home expenditures in those states, respectively.[5] In response, chains have divested of most facilities in these states, a phenomenon documented in our analyses. Although litigation trends appear to have abated somewhat in recent years,[22] it is unclear whether litigation will spread to new and greater numbers of states in future years, potentially undercutting organizations' abilities to avoid these risks.

Importantly, the findings of our analyses show that there is substantial variation across chain providers in their practices and strategies by which they navigate policy and market conditions. Thus, in researching nursing home chains in comparison to the rest of the nursing home industry, it is important to focus beyond the dichotomous "Yes/No" of whether a facility is part of a chain and to investigate more about the specific characteristics of the parent company. Is the chain regional or national? Is the chain in a period of expansion, contraction, or stability? Which resident payer sources are most important to the parent company (e.g., does the company emphasize Medicare and post-acute care)? Does the chain have a substantial investment in rehabilitation, hospice, home health, or assisted living? Does the chain have a substantial reliance on REIT financing or does it own most of its real estate assets? Although the answers to these and other questions influence the potential impact of future policy and market conditions on the industry as a whole, they also give insights into their likely differential impact on particular providers.

Some of the trends outlined above have unclear implications for the quality of care received by nursing home residents. For example, it is unclear whether the current trend toward REIT financing has any implications for nursing home quality. Although the same entities may remain as operators, the landlords from which they rent have strategic interests that are separate from the health care mission of their tenants. These landlords may have little experience or interest in nursing home care *per se*, perhaps influencing the ability of operating companies to institute changes to improve quality of care (e.g., at least related to the physical capital). Moreover, if a REIT seeks increased rent payments (as recently has happened with Kindred and its landlord Ventas), the nursing home operator could be constrained in its ability to meet increased costs. In particular, the profit and loss model of nursing homes is relatively fixed, with limited places to seek additional resources (e.g., lower insurance costs, reduced operating expenses, and reduced capital expenditures). In addition, because of the highly leveraged structure of this arrangement, operators can be vulnerable to future negative impacts from reimbursement changes.

Another side-effect of separating real estate assets from operations is that it reduces the assets available to potential litigants, possibly reducing incentives for plaintiffs and their attorneys to bring lawsuits. In fact, the trends toward REIT financing and those of incorporating individual facilities as separate entities can be undertaken primarily to address litigation exposure.[22] REITs typically create special purpose bankruptcy remote limited liability corporations to mitigate the high cost of insurance and to minimize the chain of liability; thus the companies -- as tenants -- have much lower levels of exposure. Although it remains unclear how successful these strategies will be in limiting liability exposure, it is apparent that liability risk has emerged as an important component of nursing home corporate strategy.

At this point, the implications of national chains departing from states like Florida and Texas are also unclear. These emerging stories are made more complicated by the composition of regional operators that have taken the national chains' place in these states and the role of REIT financing. In Florida for example, Formation Capital LLC, a privately held REIT that emphasizes senior housing, purchased facilities from Beverly, Genesis, and Mariner Healthcare and then hired Sea Crest Health Care Management to operate the facilities.[23] OSCAR data show only the emergent role of Sea Crest Health Care Management in operating the facilities (described above) but not the role of Formation Capital in the financial transactions.[b] The purchasing entities in these states presumably anticipate that they can successfully limit their liability exposure, either through their corporate structuring, through improved litigation environments in these states (e.g., post tort reform), or through a combination of both. Although it is debatable whether such operator-owner relationships could impact quality of care or other practices, it is important to investigate these arrangements and inform policymakers and other stakeholders with objective data on the matter.

[b] A more recent addendum to these Formation Capital deals was the June 2006 sale of 186 SNFs and more than 21,000 beds (the facilities stretched across 21 states, but almost half were in Florida alone) to GE Healthcare Financial Services for $1.4 billion.

Unfortunately, research into topics of nursing home ownership is made difficult by the lack of comprehensive data on ownership. OSCAR data list nursing homes' operating companies over time, but they do not include data about whether these same companies own the real estate at particular locations, nor do they include any information about companies that might have substantial real estate holdings across the nursing home industry. For this project, it was hoped that data from CMS's Provider Enrollment, Chain, and Ownership System would prove useful on these matters. However, analyses with these data did not proceed because of concerns with data quality and completeness.

In conclusion, the nursing home industry today seems to be enjoying a period of relative financial health with increases in Medicare payments from initial BBA levels and recent stability, an increased role for profitable hospice and rehabilitation services in nursing homes, more reasonable acquisition and debt strategies relative to previous years, and relatively stable Medicaid payments in recent years. Looking at past trends, however, demonstrates that these conditions can change quickly as a result of policy, market, or other factors. If Medicare further constrains SNF or hospice payments (e.g., as MedPAC has recently recommended[24,25]), if malpractice litigation costs continue to increase in particular states,[22] if assisted living continues to erode nursing home occupancy rates and access to private pay residents,[1] or if states begin to limit Medicaid spending by reducing increases in nursing home rates,[21] chain nursing homes and the industry as a whole could be pressed financially. The debt structures and corporate positioning of national chains should make many of these companies better able to weather coming storms and to protect against possible financial shocks. As outlined above, however, further research is ultimately needed to investigate these trends more thoroughly and to analyze whether they have had any impact on nursing home residents' quality of care or quality of life.

REFERENCES

1. Grabowski DC, Stevenson DG. Assisted Living Expansion and the Market for Nursing Home Care. *Health Aff (Millwood)*. In press.

2. Bourdon TW, Dubin S. *Long-Term Care: General Liability and Professional Liability, Actuarial Analysis.* New York, NY: Aon Actuarial Solutions, Inc.; 2002.

3. Bourdon TW, Dubin S. *Long-Term Care: General Liability and Professional Liability, Actuarial Analysis.* New York, NY: Aon Risk Consultants, Inc.; 2003.

4. Bourdon TW, Dubin S. *Long-Term Care: General Liability and Professional Liability, Actuarial Analysis.* New York, NY: Aon Risk Consultants, Inc.; 2004.

5. Stevenson DG, Studdert DM. The rise of nursing home litigation: findings from a national survey of attorneys. *Health Aff (Millwood)*. March-April 2003; 22(2):219-229.

6. Manton KG, Gu X, Lamb VL. Change in chronic disability from 1982 to 2004/2005 as measured by long-term changes in function and health in the U.S. elderly population. Vol 103; 2006:18374-18379.

7. Liu K, Gage B, Harvell J, Stevenson D, Brennan N. Medicare's Post-Acute Care Benefit: Background, Trends, and Issues to Be Faced. Washington, DC: The Urban Institute; January 1999. Contract: HHS-100-97-0010. Available at http://aspe.hhs.gov/daltcp/reports/mpacb.htm.

8. Hearing on Nursing Home Bankruptcies. *Special Committee on Aging.* John Ransom, Political Transcripts by Federal Document Clearing House; 2000.

9. Irving Levin Associates. *The Senior Care Acquisition Market: Decade in Review.* New Canaan, CT: Irving Levin Associates, Inc.; July 2000.

10. Peck RL. "People will pay us to keep them home..." Interview with Genesis Health Ventures Chairman and CEO Michael R. Walker. *Nursing Homes.* July 17, 1997; 46(7).

11. Wiener JM, Stevenson DG, Goldenson SM. Controlling the supply of long-term care providers in thirteen states. *J Aging Soc Policy.* 1999; 10(4):51-72.

12. Business Brief-Sun Healthcare Group Inc. Earnings for Third Quarter Won't Meet Expectations. *The Wall Street Journal.* September 29, 1998.

13. Genesis Health Warns 4th-Quarter Results Will Miss Estimates. November 2, 1998.

14. Crippen DL. Hearing On the Impact of Balanced Budget Act on the Medicare Fee-for-Service Program. *Committee on Commerce*. Washington, DC; 1999.

15. Kumpel JJ, Dewhurst A. *Skilled Nursing Facilities: The Phoenix Rises Again*. December 20, 2004.

16. U.S. General Accounting Office. *SNF, Medicare Payments Exceed Costs for Most but Not All Facilities*. December 2002.

17. Fischbeck K, Feinstein AT. *Lehman Health Care Facilities SNF Report: Monthly Analysis of Statistics, Numbers, and Financials for the Skilled Nursing Facility Industry*. Lehman Brothers; June 7, 2004.

18. BDO Seidman, LLP. *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*. April 2005.

19. Fischbeck K, Feinstein AT. *SNF Report: Monthly Analysis of Statistics, Numbers, and Financials for the Skilled Nursing Facility Industry*. Lehman Brothers; January 4, 2005.

20. MedPAC. *Report to the Congress: Medicare Payment Policy. Section 3C Skilled Nursing Facility Services*. Available at http://www.medpac.gov/publications/congressional_reports/Mar04_Entire_reportv3.pdf.

21. Grabowski DC, Feng Z, Intrator O, Mor V. Recent trends in state nursing home payment policies. *Health Aff (Millwood)*. January-June 2004; Suppl Web Exclusives:W4-363-373.

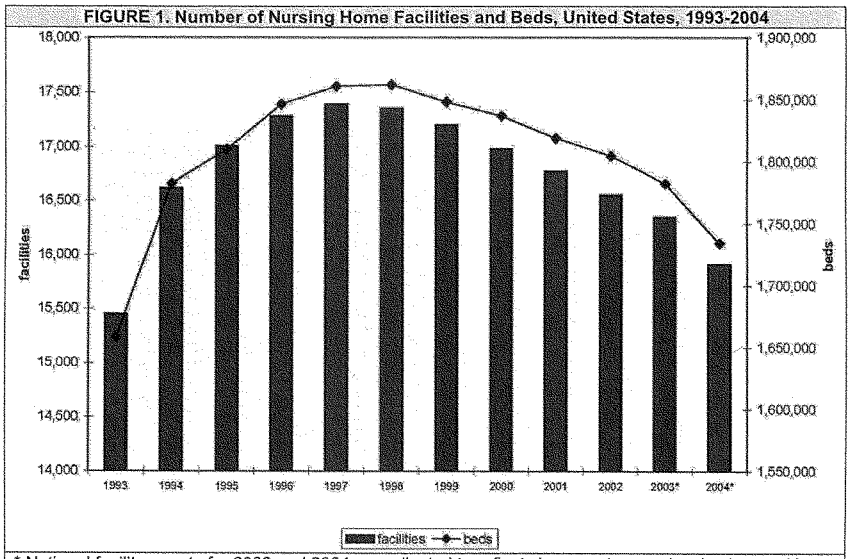
22. Bourdon TW, Dubin SC. Long Term Care: 2005 General Liability and Professional Liability Benchmark Analysis. Aon Risk Consultants. Available at http://www.ahca.org/brief/aon_ltcanalysis2005.pdf.

23. Formation Capital Deals. *Senior Care Investor*. July 2006. Accessed at http://www.levinassociates.com/publications/sci/sciheadlines/06%20scihead/607scihead.htm.

24. MedPAC. *Skilled Nursing Facility Services*. Washington, DC; March 2006.

25. MedPAC. *Hospice in Medicare: Recent Trends and a Review of the Issues*. Washington, DC; 2006.

FIGURE 1. Number of Nursing Home Facilities and Beds, United States, 1993-2004



* National facility counts for 2003 and 2004 are adjusted to reflect closure rates previously observed in OSCAR data (which are determined as subsequent data become available). These totals are subject to revision.

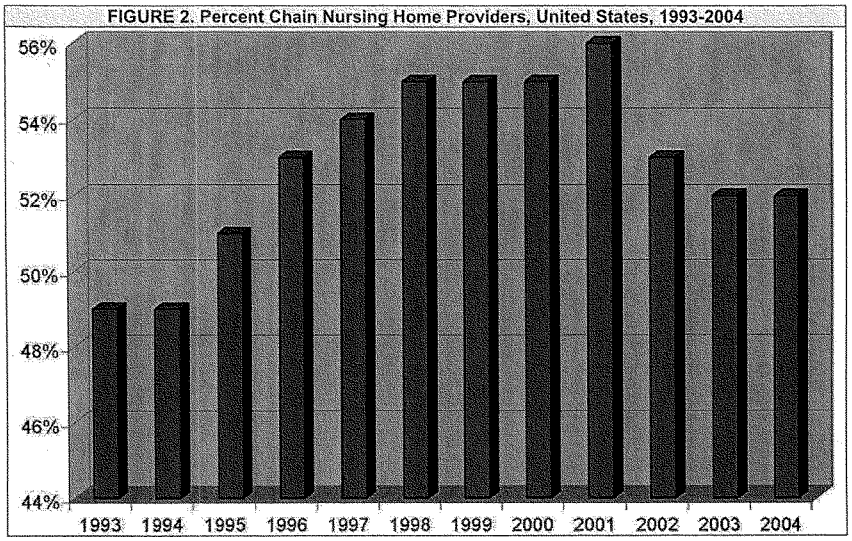


FIGURE 2. Percent Chain Nursing Home Providers, United States, 1993-2004
56%
54%
52%
50%
48%
46%
44%
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004

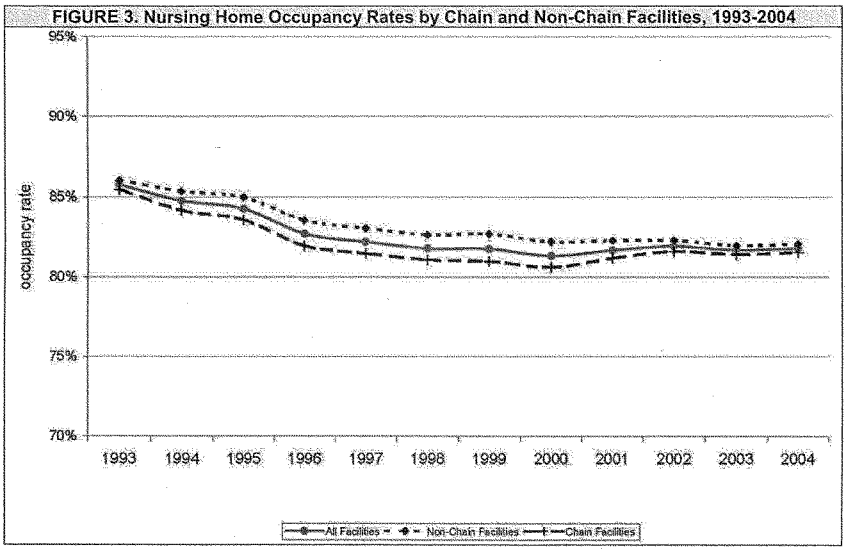


FIGURE 3. Nursing Home Occupancy Rates by Chain and Non-Chain Facilities, 1993-2004
95%
90%
85%
80%
75%
70%
occupancy rate
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
All Facilities
Non-Chain Facilities
Chain Facilities

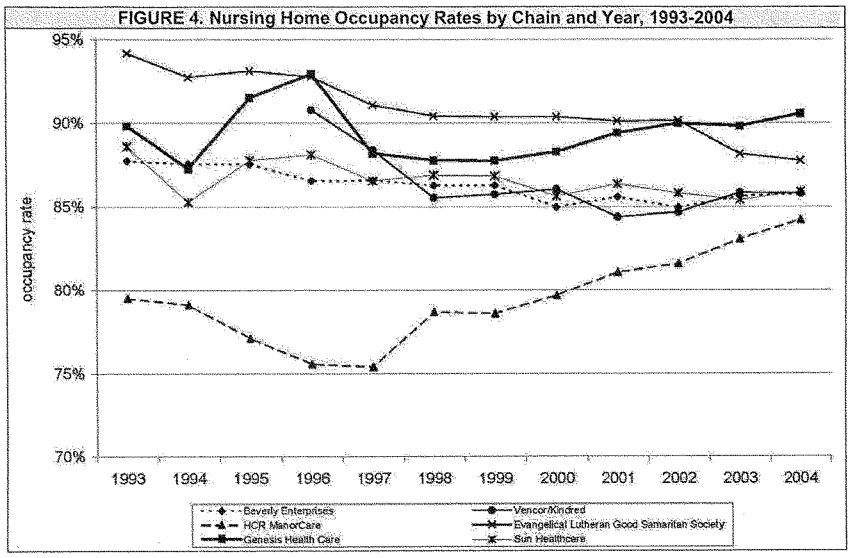


FIGURE 4. Nursing Home Occupancy Rates by Chain and Year, 1993-2004
95%
90%
85%
80%
75%
70%
occupancy rate
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
Beverly Enterprises
HCR ManorCare
Genesis Health Care
Vencor/Kindred
Evangelical Lutheran Good Samaritan Society
Sun Healthcare

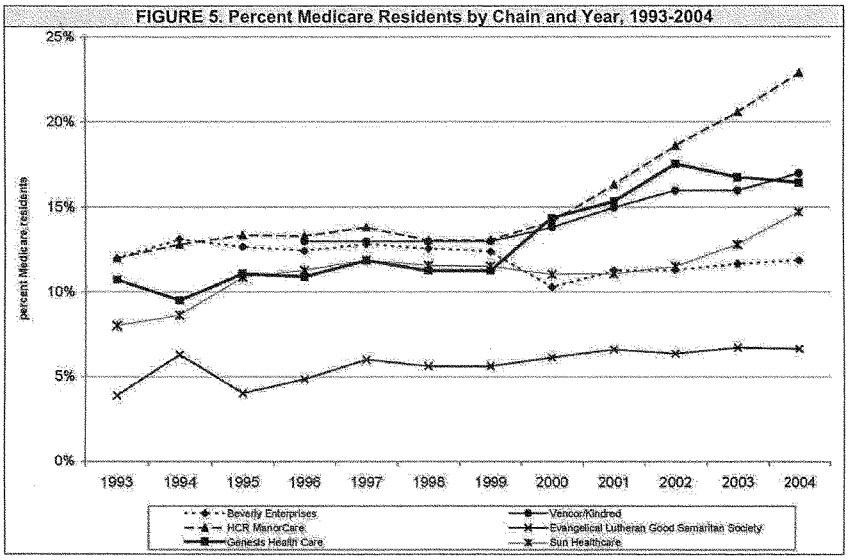


FIGURE 5. Percent Medicare Residents by Chain and Year, 1993-2004
25%
20%
15%
10%
5%
0%
percent Medicare residents
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
Beverly Enterprises
HCR ManorCare
Genesis Health Care
Vencor/Kindred
Evangelical Lutheran Good Samaritan Society
Sun Healthcare

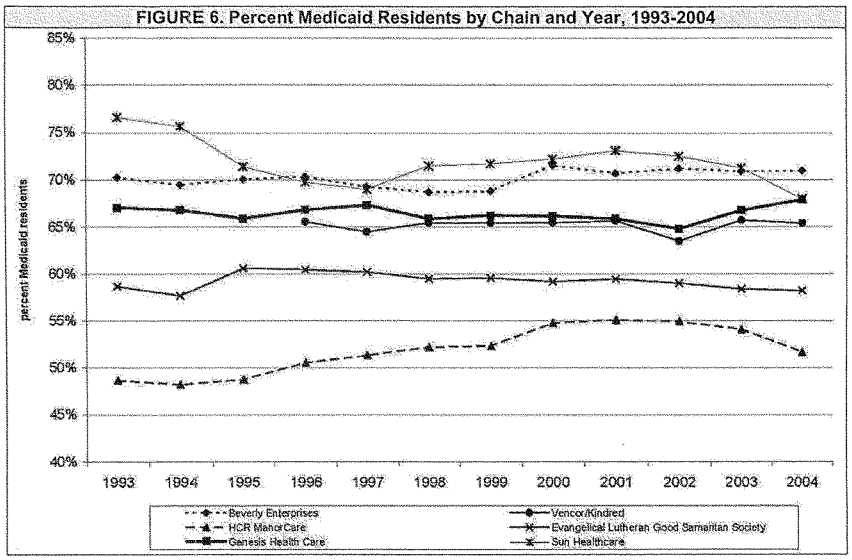


FIGURE 6. Percent Medicaid Residents by Chain and Year, 1993-2004
85%
80%
75%
70%
65%
60%
55%
50%
45%
40%
percent Medicaid residents
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
Beverly Enterprises
HCR ManorCare
Genesis Health Care
Vencor/Kindred
Evangelical Lutheran Good Samaritan Society
Sun Healthcare

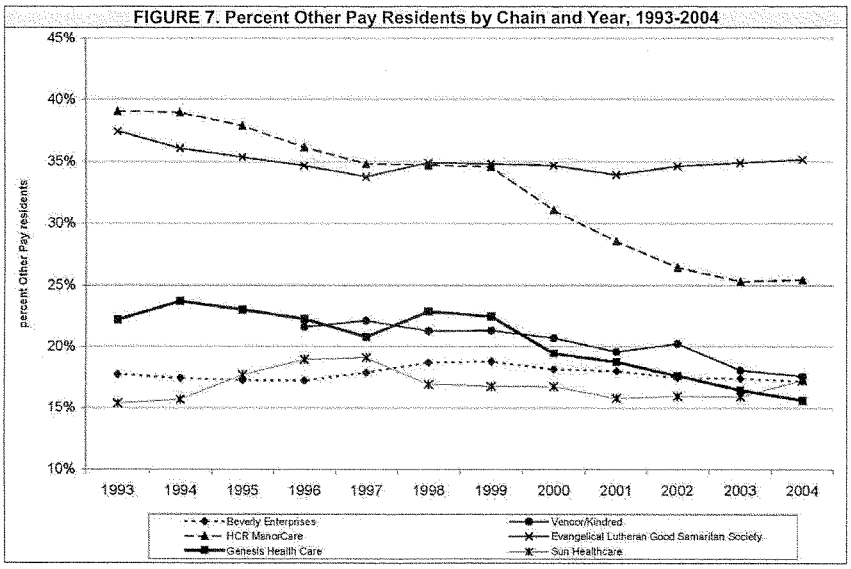


TABLE 1. Percent of Chain Nursing Homes by Year					
Year	Chain Facilities	Total Facilities	Percent	Top 5 Chains** as a Percent of the Total Chain Facilities	Top 10 Chains** as a Percent of the Total Chain Facilities
1993	7,508	15,450	49%	19%	25%
1994	8,197	16,618	49%	17%	23%
1995	8,667	17,003	51%	16%	22%
1996	9,078	17,280	53%	14%	21%
1997	9,313	17,388	54%	14%	22%
1998	9,471	17,355	55%	16%	24%
1999	9,433	17,204	55%	16%	24%
2000	9,376	16,982	55%	17%	27%
2001	9,309	16,772	56%	16%	26%
2002	8,717	16,559	53%	17%	26%
2003*	9,180	17,585	52%	15%	23%
2004*	8,921	17,113	52%	15%	22%

* 2003 and 2004 counts are unadjusted and likely include facilities that have closed. In particular, our methodology for identifying closures relies on using two subsequent years of OSCAR data.
** Top 5 and Top 10 chains vary by year and are ranked based on number of facilities.

TABLE 2. Total Number of Facilities and Beds by Chain and Year, 1993-2004 (Top 10 Chains in Any Year)

Chain Provider	1993 facilities (beds)	1994 facilities (beds)	1995 facilities (beds)	1996 facilities (beds)	1997 facilities (beds)	1998 facilities (beds)	1999 facilities (beds)	2000 facilities (beds)	2001 facilities (beds)	2002 facilities (beds)	2003 facilities (beds)	2004 facilities (beds)
BEVERLY ENTERPRISES	766 (81,372)	743 (79,675)	708 (76,042)	652 (72,342)	593 (65,809)	555 (61,464)	552 (60,775)	532 (58,642)	484 (52,969)	454 (49,020)	426 (45,258)	377 (39,196)
KINDRED HEALTHCARE[1]								42 (4,990)	291 (37,438)	277 (35,463)	259 (32,990)	252 (31,887)
VENCOR[1]	1 (16)	3 (105)	10 (1,022)	144 (18,364)	223 (28,677)	264 (34,395)	260 (33,301)	241 (30,896)				
HILLHAVEN[1]	200 (24,609)	189 (22,765)	171 (21,405)	55 (6,851)	16 (2,265)	8 (1,086)	8 (1,086)	2 (242)				
HEALTH CARE & RETIREMENT (HCR)[2]	115 (14,477)	118 (14,338)	122 (14,794)	120 (14,653)	104 (12,668)	1 (100)						
MANOR CARE[2]	148 (20,351)	148 (20,646)	154 (21,564)	156 (21,666)	179 (25,507)	281 (37,746)	280 (37,746)	292 (39,264)	289 (38,974)	282 (38,291)	292 (39,647)	279 (37,375)
MARINER HEALTH CARE[3]	8 (859)	14 (1,575)	26 (2,907)	55 (6,911)	68 (9,041)	136 (16,881)	137 (17,164)	241 (29,566)	238 (28,895)	266 (32,455)	238 (29,286)	201 (24,542)
EVANG. LUTHERAN GOOD SAMARITAN SOC.	192 (16,354)	198 (16,691)	208 (17,406)	205 (17,229)	202 (16,797)	201 (16,605)	204 (16,802)	196 (15,620)	194 (15,421)	188 (14,837)	196 (15,417)	189 (14,650)
GENESIS HEALTH CARE[4]	31 (4,326)	47 (6,467)	59 (8,452)	81 (10,952)	127 (17,392)	190 (24,947)	190 (25,051)	200 (25,659)	188 (24,477)	182 (23,971)	176 (22,809)	167 (21,630)
HORIZON/CMS HEALTH CARE[5]	75 (8,521)	93 (11,096)	124 (15,092)	134 (15,262)	104 (12,206)	25 (3,308)	25 (3,361)	10 (1,710)	7 (1,149)			
INTEGRATED HEALTH SERVICES[6]	39 (5,084)	81 (10,585)	106 (13,365)	126 (16,134)	139 (17,384)	228 (26,927)	230 (27,028)	238 (29,130)	222 (27,274)	174 (21,188)	89 (10,194)	12 (1,247)
TRANS HEALTHCARE[6]								9 (685)	32 (2,360)	40 (3,467)	85 (9,087)	125 (13,077)
SUN HEALTHCARE[7]	41 (4,407)	72 (7,978)	102 (11,596)	128 (14,717)	164 (19,155)	260 (29,848)	262 (30,259)	272 (31,123)	234 (26,606)	213 (24,310)	169 (17,986)	95 (9,288)
COLUMBIA/HCA HEALTHCARE[8]	5 (83)	36 (1,005)	91 (2,497)	136 (4,326)	143 (4,979)	121 (3,235)	113 (2,870)	67 (1,605)	29 (799)	5 (203)	13 (267)	4 (205)
UNICARE HEALTH FACILITIES	113 (12,136)	117 (12,338)	116 (12,358)	111 (11,580)	72 (7,255)	11 (1,178)	11 (1,178)	4 (446)				
LIFE CARE CENTERS OF AMERICA	74 (10,000)	99 (12,920)	114 (14,904)	132 (17,057)	137 (18,062)	136 (17,863)	137 (17,894)	148 (19,103)	139 (18,221)	126 (16,012)	127 (16,146)	133 (17,180)
EXTENDICARE HEALTH SERVICES	3 (186)	3 (210)	3 (210)	15 (1,123)	64 (6,238)	157 (16,339)	163 (16,829)	152 (15,280)	149 (15,101)	132 (13,464)	132 (13,418)	133 (13,650)
TEXAS HEALTH ENTERPRISES	97 (10,803)	99 (11,126)	93 (10,316)	99 (10,676)	95 (9,982)	99 (10,581)	102 (10,914)	68 (7,337)	60 (6,515)	3 (256)	1 (102)	
FIRST HEALTHCARE	74 (10,244)	96 (13,569)	98 (12,987)	74 (9,889)	53 (7,429)	29 (4,170)	29 (4,170)	11 (1,748)	9 (1,564)	7 (1,413)	6 (1,155)	2 (315)

TABLE 2 (*continued*)												
Chain Provider	1993 facilities (beds)	1994 facilities (beds)	1995 facilities (beds)	1996 facilities (beds)	1997 facilities (beds)	1998 facilities (beds)	1999 facilities (beds)	2000 facilities (beds)	2001 facilities (beds)	2002 facilities (beds)	2003 facilities (beds)	2004 facilities (beds)
LIVING CENTERS OF AMERCA	85 (9,252)	109 (11,652)	119 (13,625)	131 (14,374)	131 (14,619)	62 (7,241)	62 (7,241)	39 (4,540)	28 (3,214)			1 (60)

1. Vencor acquired Hillhaven facilities around 1995; Vencor went bankrupt in 1999 and re-emerged as Kindred in 2001.
2. Health Care Retirement merged with Manor Care in 1998. Includes Manor Care and HCR Manor Care facilities to reflect merger with HCR.
3. Paragon and Mariner merged in 1998 and were named the Mariner Post Acute Network. Mariner went bankrupt in 2000 and later merged with National Senior Care in 2004.
4. Genesis went bankrupt in 2000.
5. Horizon/CMS Health Care facilities were purchased by Integrated Health Services/Trans Healthcare in 1997.
6. Integrated Health Services went bankrupt and their facilities were taken over by Trans Healthcare in 1999.
7. Sun Healthcare includes Sunrise and Sunbridge facilities. Sun Healthcare went bankrupt in 1999.
8. Columbia merged with HCA in 1994 to become Columbia/HCA Healthcare.

TABLE 3. Number of States* in which Chains Operated by Year, 1993-2004												
Chain Provider	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
BEVERLY ENTERPRISES	34	36	36	34	33	33	32	30	30	28	27	27
VENCOR/KINDRED	1	3	7	27	29	32	32	31	32	32	32	29
HILLHAVEN CORPORATION	32	31	31	21	10	5	5	1	0	0	0	0
HCR/MANORCARE	33	32	31	31	31	31	31	31	31	31	30	30
MARINER HEALTH CARE	3	8	11	17	17	23	23	23	24	23	23	21
EVANG. LUTHERAN GOOD SAMARITAN SOC.	25	26	26	25	25	25	25	24	23	25	24	24
GENESIS HEALTH CARE	7	11	12	13	16	19	19	17	16	16	15	14
HORIZON/CMS HEALTH CARE	14	16	20	23	21	12	11	3	3	0	0	0
INTEGRATED HEALTH SERVICES	17	22	24	29	29	31	31	29	28	24	21	10
SUN HEALTHCARE	8	11	14	17	22	25	25	25	24	25	25	14
COLUMBIA/HCA HEALTHCARE CORPORATION	3	13	21	28	29	27	27	21	14	4	10	4
UNICARE HEALTH FACILITIES	13	13	12	10	10	6	6	2	0	0	0	0

* Includes the District of Columbia.

TABLE 4. Number of Chain-Operated Facilities in Florida by Chain and Year												
Chain Provider	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
BEVERLY ENTERPRISES	59	62	60	58	55	49	50	36	6	0	0	0
HEALTH CARE & RETIREMENT CORP[1]	19	20	22	22	19	0	0	0	0	0	0	0
UNICARE HEALTH FACILITIES	13	14	12	14	12	2	2	0	0	0	0	0
NATIONAL HEALTHCARE CORPORATION	11	11	11	10	11	12	12	1	0	2	0	1
MANOR CARE[1]	9	9	10	12	16	34	33	37	36	33	34	30
HILLHAVEN CORPORATION[2]	8	8	10	2	0	0	0	0	0	0	0	0
LIFE CARE CENTERS OF AMERICA	3	3	6	7	9	9	10	12	9	8	12	11
INTEGRATED HEALTH SERVICES	2	16	23	26	27	34	34	49	41	21	5	1
COLUMBIA/HCA HEALTHCARE CORP[3]	2	5	13	23	18	19	19	10	1	0	1	0
DELTA HEALTH GROUP	0	0	2	5	6	12	14	26	28	31	33	33
SEA CREST HEALTH CARE MANAGEMENT	0	0	0	0	0	0	0	0	3	47	54	25
TANDEM HEALTH CARE	0	0	0	0	0	1	1	18	19	21	21	21
HOME QUALITY MANAGEMENT	0	0	0	0	0	0	0	1	3	10	11	14
MARINER HEALTH CARE	0	0	7	18	23	25	25	28	28	28	4	1
KINDRED HEALTHCARE[2]	0	0	0	0	0	0	0	4	19	18	3	0
EXTENDICARE HEALTH SERVICES	0	0	0	0	3	16	17	1	2	0	0	0
GENESIS HEALTH CARE	0	1	5	6	13	13	12	9	9	7	1	0
VENCOR[2]	0	0	0	4	10	13	12	14	0	0	0	0

1. Health Care Retirement merged with Manor Care in 1998. Includes Manor Care and HCR Manor Care facilities to reflect merger with HCR.
2. Vencor acquired Hillhaven facilities around 1995. Vencor went bankrupt in 1999 and re-emerged as Kindred in 2001.
3. Columbia merged with HCA in 1994 to become Columbia/HCA Healthcare.

TABLE 5. Number of Chain-Operated Facilities in Texas by Chain and Year

Chain Provider	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
BEVERLY ENTERPRISES	109	77	46	49	21	1	0	0	0	0	0	0
TEXAS HEALTH ENTERPRISES	94	97	92	98	94	98	101	68	60	3	1	0
LIVING CENTERS OF AMERICA	48	56	61	61	53	24	24	18	17	0	0	1
LIVING CENTERS OF TEXAS	44	42	37	31	32	20	19	22	17	8	8	15
UNICARE HEALTH FACILITIES	13	15	15	15	9	0	0	0	0	0	0	0
MANOR CARE[1]	7	7	10	6	10	10	10	11	11	17	16	11
SUMMIT CARE CORPORATION	5	8	20	22	22	23	22	20	19	14	10	2
SUN HEALTHCARE[2]	4	14	15	21	24	26	27	25	20	8	4	0
INTEGRATED HEALTH SERVICES	3	12	19	15	14	27	27	32	34	24	14	0
COLUMBIA/HCA HEALTHCARE[3]	2	15	33	38	39	32	28	18	10	2	4	1
DAYBREAK HEALTHCARE	0	0	0	0	0	0	0	0	1	47	59	74
MARINER HEALTH CARE[4]	0	0	0	9	10	23	23	45	49	63	63	54
SENIOR LIVING PROPERTIES	0	0	0	0	0	27	27	43	44	46	48	47
TRANS HEALTHCARE	0	0	0	0	0	0	0	0	0	0	3	18
TENET HEALTHCARE	0	0	4	10	14	13	14	6	5	4	6	5
EXTENDICARE HEALTH SERVICES	0	0	0	0	8	18	18	17	14	0	1	0
HEALTHCARE CENTERS OF TEXAS	0	24	52	57	55	23	22	10	7	1	1	0
PARAGON HEALTH NETWORK[4]	0	0	0	0	0	19	19	7	6	0	0	0

1. Health Care Retirement merged with Manor Care in 1998. Includes Manor Care and HCR Manor Care facilities to reflect merger with HCR.
2. Sun Healthcare includes Sunrise and Sunbridge facilities. Sun Healthcare went bankrupt in 1999.
3. Columbia merged with HCA in 1994 to become Columbia/HCA Healthcare.
4. Paragon and Mariner merged in 1998 and were named the Mariner Post Acute Network. Mariner went bankrupt in 2000 and later merged with National Senior Care in 2004.

GAO
Accountability·Integrity·Reliability
Highlights

Highlights of GAO-07-241, a report to the Ranking Minority Member, Committee on Finance, U.S. Senate

Why GAO Did This Study

In 1998 and 1999 reports, GAO concluded that enforcement actions, known as sanctions, were ineffective in encouraging nursing homes to maintain compliance with federal quality requirements: sanctions were often rescinded before being implemented because homes had a grace period to correct deficiencies. In response, the Centers for Medicare & Medicaid Services (CMS) began requiring immediate sanctions for homes that repeatedly harmed residents. Using CMS enforcement and deficiency data, GAO (1) analyzed federal sanctions from fiscal years 2000 through 2005 against 63 homes previously reviewed and (2) assessed CMS's overall management of enforcement. The 63 homes had a history of harming residents and were located in 4 states that account for about 22 percent of homes nationwide.

What GAO Recommends

GAO recommends that the CMS Administrator (1) develop an administrative process for collecting civil money penalties more expeditiously and seek legislation to implement this process effectively, as appropriate; (2) strengthen its immediate sanctions policy; (3) expand its oversight of homes with a history of harming residents; and (4) improve the effectiveness of its enforcement data systems. CMS generally concurred with GAO's recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-07-241.

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.

March 2007

NURSING HOMES

Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents

What GAO Found

From fiscal years 2000 through 2005, the number of sanctions decreased for the 63 nursing homes GAO reviewed that had a history of serious quality problems, a decline consistent with nationwide trends. While the decline may reflect improved quality or changes to enforcement policy, it may also mask survey weaknesses that understate quality problems, an issue GAO has reported on since 1998. Although the number of sanctions decreased, the homes generally were cited for more deficiencies that caused harm to residents than other homes in their states. Almost half of the homes reviewed continued to cycle in and out of compliance; 19 did so 4 times or more. These homes temporarily corrected deficiencies and, even with sanctions, were again found out of compliance on subsequent surveys. Several weaknesses appeared to undermine the effectiveness of the sanctions implemented against the homes reviewed. First, civil money penalties (CMP), which by statute are not paid while under appeal—a process that can take years—were generally imposed at the lower end of the allowable dollar range. For example, the median per day CMP ranged from $350 to $500, significantly below the maximum of $3,000 per day. Second, CMS favored the use of sanctions that give homes more time to correct deficiencies, increasing the likelihood that the sanctions would not be implemented. Thus, more than half of the denial of payment for new admissions (DPNA) that CMS imposed were the type that give homes 3 months to correct deficiencies rather than those that only give homes up to 15 days. Third, there was no record of a sanction for about 22 percent of the homes reviewed that met CMS's criteria for immediate sanctions, a problem GAO also identified in 2003; moreover, 60 percent of DPNAs imposed as immediate sanctions were not implemented until 1 to 2 months after citation of the deficiency. Finally, involuntary termination of homes from participating in the Medicare or Medicaid programs was rare because of concerns about access to other nearby homes and resident transfer trauma; 2 of the 63 homes reviewed were involuntarily terminated because of quality problems.

CMS's management of enforcement is hampered by the complexity of its immediate sanctions policy and by its fragmented and incomplete data. Its policy allows some homes with the worst compliance histories to escape immediate sanctions. For example, a home cited with a serious deficiency and that has not yet corrected an earlier serious deficiency is spared an immediate sanction. Such rules may in part explain why the 63 homes reviewed only had 69 instances of immediate sanctions over a 6-year period despite being cited 444 times for deficiencies that harmed residents. Although CMS initiated development of a new enforcement data system 6 years ago, it is fragmented and has incomplete national reporting capabilities. CMS is taking additional steps to improve nursing home enforcement, such as developing guidance to encourage more consistency in CMP amounts, but it is not clear whether and when these initiatives will address the enforcement weaknesses GAO found.

May 2007

GAO
Accountability·Integrity·Reliability

Highlights

Highlights of GAO-07-373, a report to the Ranking Member, Committee on Finance, U.S. Senate

NURSING HOMES

Federal Actions Needed to Improve Targeting and Evaluation of Assistance by Quality Improvement Organizations

Why GAO Did This Study

In 2002, CMS contracted with Quality Improvement Organizations (QIO) to help nursing homes address quality problems such as pressure ulcers, a deficiency frequently identified during routine inspections conducted by state survey agencies. CMS awarded $117 million over a 3-year period to the QIOs to assist all homes and to work intensively with a subset of homes in each state. Homes' participation was voluntary. To evaluate QIO performance, CMS relied largely on changes in homes' quality measures (QM), data based on resident assessments routinely conducted by homes. GAO assessed QIO activities during the 3-year contract starting in 2002, focusing on (1) characteristics of homes assisted intensively, (2) types of assistance provided, and (3) effect of assistance on the quality of nursing home care. GAO conducted a Web-based survey of all 51 QIOs, visited QIOs and homes in five states, and interviewed experts on using QMs to evaluate QIOs.

What GAO Recommends

GAO recommends that the CMS Administrator (1) further increase the number of low-performing homes that QIOs work with intensively, (2) improve monitoring and evaluation of QIO activities, and (3) require QIOs to share with CMS the identity of homes assisted intensively in order to facilitate evaluation. CMS agreed with the first two recommendations, but did not specifically indicate if it agreed with the third.

www.gao.gov/cgi-bin/getrpt?GAO-07-373.

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

What GAO Found

Although more homes volunteered to work with the QIOs than CMS expected them to assist intensively, QIOs typically did not target their assistance to the low-performing homes that volunteered. Most QIOs' primary consideration in selecting homes was their commitment to working with the QIO. CMS did not specify selection criteria for intensive participants but contracted with a QIO that developed guidelines encouraging QIOs to select committed homes and exclude those with many survey deficiencies or QM scores that were too good to improve significantly. Consistent with the guidelines, few QIOs targeted homes with a high level of survey deficiencies, and eight QIOs explicitly excluded these homes. GAO's analysis of state survey data confirmed that selected homes were less likely than other homes to be low-performing in terms of identified deficiencies. Most state survey and nursing home trade association officials interviewed by GAO believed QIO resources should be targeted to low-performing homes.

QIOs were provided flexibility both in the QMs on which they focused their work with nursing homes and in the interventions they used. Most QIOs chose to work on chronic pain and pressure ulcers, and most used the same interventions—conferences and distribution of educational materials—to assist homes statewide. The interventions used to assist individual homes intensively varied and included on-site visits, conferences, and small group meetings. Just over half the QIOs reported that they relied most on on-site visits to assist intensive participants. Sixty-three percent said such visits were their most effective intervention. Of the 15 QIOs that would have changed the interventions used, most would make on-site visits their primary intervention. Homes indicated that they were less satisfied with the program when their QIO experienced high staff turnover or when their QIO contact possessed insufficient expertise.

Shortcomings in the QMs as measures of nursing home quality and other factors make it difficult to measure the overall impact of the QIOs on nursing home quality, although staff at most of the nursing homes GAO contacted attributed some improvements in the quality of resident care to their work with the QIOs. The extent to which changes in homes' QM scores reflect improvements in the quality of care is questionable, given the concerns raised by GAO and others about the validity of the QMs and the reliability of the resident assessment data used to calculate them. In addition, quality improvements cannot be attributed solely to the QIOs, in part because the homes that volunteered and were selected for intensive assistance may have differed from other homes in ways that would affect their scores; these homes may also have participated in other quality improvement initiatives. Ongoing CMS evaluation of QIO activities for the contract that began in August 2005 is being hampered by a 2005 Department of Health and Human Services decision that QIO program regulations prohibit QIOs from providing to CMS the identities of homes being assisted intensively.

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

GAO-07-794T

GAO
Accountability·Integrity·Reliability
Highlights

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

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.

May 2, 2007

NURSING HOME REFORM

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

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 expected 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.[5] 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.

[5]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.

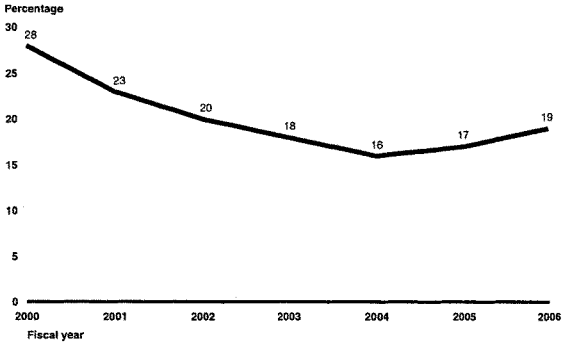
comparative survey involves a federal survey team conducting a complete, independent survey of a home within 2 months of the completion of a state's survey in order to compare and contrast the findings. In an observational survey, one or more federal surveyors accompany a state survey team to a nursing 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

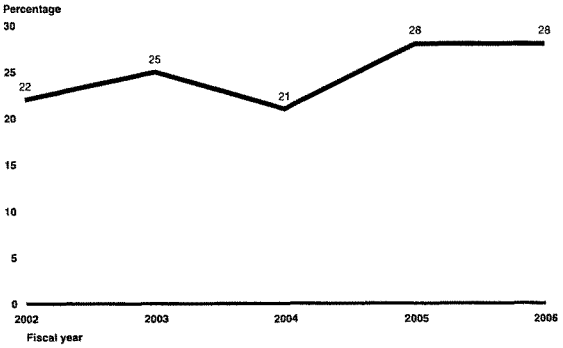
survey agency salaries are rarely competitive with the private sector.[14] Moreover, the first year for a new surveyor is essentially a training period with low productivity. It can take as long as 3 years for a surveyor to gain sufficient knowledge, experience, and confidence to perform the job well. 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.

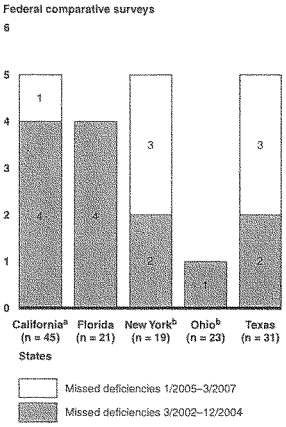
In December 2005, we reported on understatement of serious deficiencies in five states—California, Florida, New York, Ohio, and Texas—from March 2002 through December 2004.[16] We selected these states for our analysis because the percentage of their state surveys that cited serious deficiencies decreased 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 that 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 and 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.

This is a work of the U.S. government and is not subject to copyright protection in the United States. It may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

GAO's Mission

The Government Accountability Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday, GAO posts newly released reports, testimony, and correspondence on its Web site. To have GAO e-mail you a list of newly posted products every afternoon, go to www.gao.gov and select "Subscribe to Updates."

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are $2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. Government Accountability Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Gloria Jarmon, Managing Director, JarmonG@gao.gov (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, D.C. 20548

Public Affairs

Paul Anderson, Managing Director, AndersonP1@gao.gov (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, D.C. 20548

PRINTED ON RECYCLED PAPER

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

Page

1. Background 1
   1.1. The Effectiveness of Enforcement 3

2. Methods 4
   2.1. Overview of Data Collection and Analysis 5
   2.2. RN Data Collectors 6
   2.3. State Facility and Care Area Selection Process 6
      2.3.1. State Selection Process 6
      2.3.2. Facility Selection 7
      2.3.3. Study Care Area and F tag Selection 8
   2.4. Data Collection 9

3. Case Study Findings 12
   3.1. Survey to Detect and Identify Deficient Practices 12
      3.1.1. CMS' Annual Re-certification Survey 12
      3.1.2. Survey Findings: Detection and Omissions 13
      3.1.3. Citation Decisions: to Cite or Not to Cite? 16
   3.2. Statement of Deficiency, Reflecting the Formal Survey Outcomes 17
      3.2.1. Citing: Regulatory Decision-Making Process 17
      3.2.2. Statement of Deficiency Findings 18
      3.2.3. Citing Practices 20
   3.3. Enforcement Actions 26
      3.3.1. CMS Enforcement Regulations: Remedies and Penalties 26
      3.3.2. Enforcement – Case Study Findings 26
      3.3.3. Enforcement Practices 28
   3.4. Revisit: Compliance Determination 33
      3.4.1. Revisit Guidelines 33
      3.4.2. Revisit Findings 33
      3.4.3. Enforcement Practices 34
   3.5. Effectiveness Enforcement in Changing Nursing Home Care? 37
      3.5.1. Enduring Changes: A Major Challenge 37
      3.5.2. Obstacles in the Regulatory Process 40

4. Discussion 42

5. Conclusions and Implications 44

References 47

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.

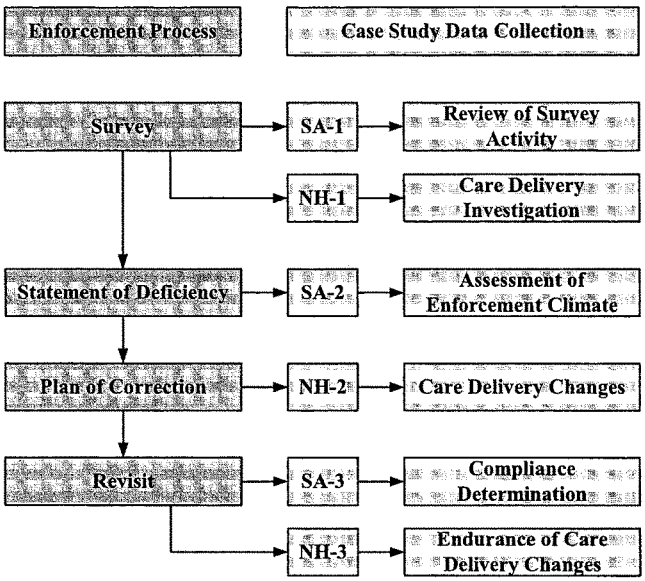
In each facility, the data collectors targeted 2-4 residents for an in-depth investigation. Residents were selected because their records indicated at-risk status for a condition relevant to one or both of the selected study care areas.

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.

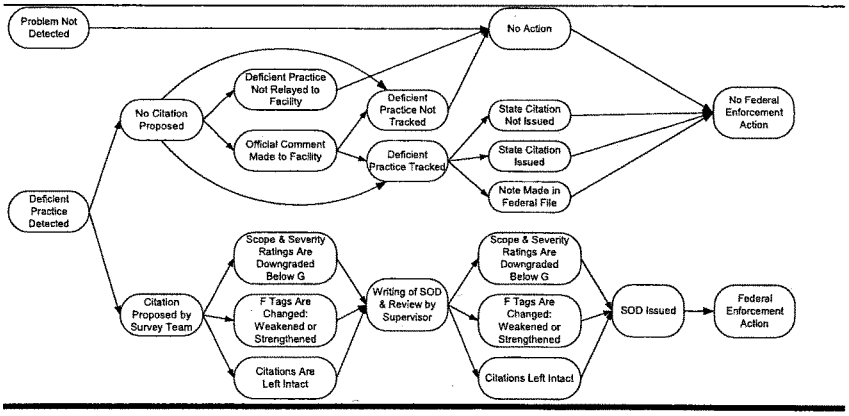
Table 4: Frequency of Omitted F Tag Citations per Facility

	# 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.'* FAC24SAI+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

#of citations	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
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

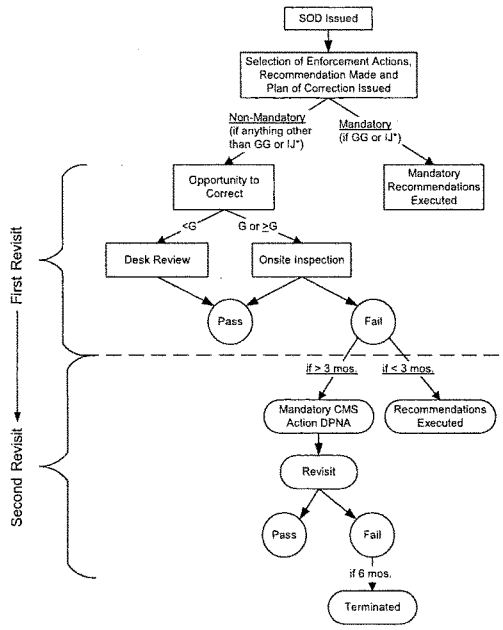
FAC94	9		1	5	3				YES	NO	NO	NO
FAC63	5			4	1				YES	NO	NO	NO
FAC18	10			6	3	1			YES	NO	NO	NO
FAC29	4	1		2	1				YES	NO	NO	NO
FAC01	4			2	2				YES	NO	NO	NO
FAC90	8			7		1			YES	NO	NO	NO
FAC21	9			6	2		1		YES	$100 (35 days)	$4,000 (1 instance)	NO
FAC49	6				1	2	3		YES	$100 (60 days)	NO	NO
FAC49	10	4		2	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.

428

Evaluation of the Quality Indicator Survey (QIS)

Contract #500-00-0032, TO#7

Final Report

December 2007

Prepared for
Marvin Feuerberg
Project Officer
Centers for Medicare
and Medicaid Services
S1-12-25
7500 Security Boulevard
Baltimore, MD 21244

Prepared by
Alan White
Jack Schnelle
Rosanna Bertrand
Kelly Hickey
Donna Hurd
David Squires
Rebecca Sweetland
Terry Moore

Contents

Executive Summary i

1. Introduction and Overview of Report 1
- 1.1. Overview 1
- 1.2. Research Questions 3

2. Accuracy of the QIS 4
- 2.1. Background 4
- 2.2. Methods: Care Process Indicators and Evaluation Approach 6
- 2.3. Description of the Data Collection Tools 16
- 2.4. Site Visit Team Training 19
- 2.5. Observation Training and Reliability Results 22
- 2.6. Methods: Site Visit 24
- 2.7. Methods: Data Management and Analyses 28
- 2.8. Results 31
- 2.9. Summary 55

3. Documentation Quality 58
- 3.1. Motivation/hypotheses 58
- 3.2. Data and Methodology 58
- 3.3. Threats to this analysis 65
- 3.4. Findings 65
- 3.5. Discussion 83

4. Outcomes of QIS Surveys 84
- 4.1. Background 85
- 4.2. Data and Methods 86
- 4.3. Findings 87
- 4.4. Discussion 102

5. Time Requirements of the QIS 105
- 5.1. Data Source 105
- 5.2. Methods 105
- 5.3. Findings 109
- 5.4. Discussion 123

6. Efficiency of QIS Surveys 125
- 6.1. Data and Methods 125
- 6.2. Findings 126
- 6.3. Discussion 138

7. Recommendations Based on Field Test Evaluation of the QIS 139
- 7.1. Features of the QIS That Were the Primary Focuses of the Field Evaluation 139
- 7.2. Major Findings from Field Evaluation That Lead to Recommendations for Improvement 140
- 7.3. Recommendations for Improvement 142

8. Quality Indicator Survey Demonstration: The Big Picture 145
8.1. Highlights of What We Have Learned 145
8.2. QIS Development 146
8.3. Findings Summary 147
8.4. Recommendations 152

References 154

Executive Summary

The QIS is a revised long-term care survey process that was developed under the Centers for Medicare & Medicaid Services (CMS) oversight through a multi-year contract. It represents an effort to standardize how the survey process measures nursing home compliance with federal standards and the interpretative guidelines that define those standards. The QIS demonstration represents the culmination of 15 years of CMS-sponsored research and development aimed at addressing criticisms of the long-term care survey process raised by consumers, providers, the General Accounting Office, Congress, survey agencies, and CMS Central Office.

The QIS is a two-staged survey process that was designed to produce a standardized resident-centered, outcome-oriented quality review. It uses an automated process that guides surveyors through a structured investigation intended to allow surveyors to systematically and objectively review all regulatory areas and subsequently focus on selected areas for further review. These features represent a departure from the Standard survey[1] process and are consistent with measurement principles deigned to improve how consistently different surveyors conduct investigations. While the survey process has been revised under the QIS, the federal regulations and interpretive guidance remain unchanged.

In the fall of 2005, CMS launched a demonstration of the QIS through surveys of record by trained state survey staff. Five states were selected to participate in the demonstration: California, Connecticut, Kansas, Louisiana, and Ohio. The evaluation of the QIS was conducted in two phases. Phase I of the evaluation, the formative evaluation, focused on ways to improve the QIS, particularly in the domains of time and efficiency. The second, summative phase of the evaluation focused on how well the QIS achieved its primary objectives of improving the accuracy, consistency, and documentation of the nursing home survey process within existing survey resources, addressing these research questions:

- ***Does the QIS lead to increased accuracy?*** The accuracy of the QIS was assessed through site visits to 20 nursing homes. While on-site, members of the research team collected data on a series of quality indicators based on protocols that were developed for several domains of nursing home care. These quality indicators give measures of the quality of care provided by the nursing home that can be compared to surveyor findings to determine whether there is more agreement between surveyor findings and the quality indicators for QIS or Standard surveys. If the QIS is more accurate than the Standard survey, then we expect that there would be a higher level of agreement between QIS survey results and the quality indicators than for Standard surveys.

- ***Does the QIS result in improved documentation of survey deficiencies?*** The question of whether the QIS leads to improved documentation was addressed using the CMS 2567 Forms generated by surveyors. We used content analysis to compare the quality of documentation review for a sample of 2567 Forms from QIS and Standard surveys, using a blind review process to measure whether the documentation supports the specific F-tag, scope and severity that was cited.

[1] Note that in this report we refer to traditional, non-QIS, surveys as Standard surveys.

- ***How does the time required to complete the QIS compare to the time required for the current survey?*** A key research question is whether the QIS requires more surveyor time than the current survey process. Using data from the CMS-670 form, we analyzed how QIS time compared to the time for the facility's prior survey and to Standard surveys at similar facilities. This analysis also examined factors that are related to survey time requirements such as facility size and the number of deficiencies cited by surveyors.

- ***How does the QIS impact the number and types of deficiencies that are cited?*** Analysis of survey deficiencies was used to examine the impact of the QIS on the number and scope/severity of deficiencies cited and also whether the QIS is associated with changes in the types of regulatory care issues that are cited. We examined survey deficiency results separately for each state and used a combination of pre-post and cross-sectional analyses to explore the impact of the QIS on survey deficiencies.

- ***Does the QIS improve surveyor efficiency?*** One of the objectives of the QIS is to improve the efficiency of surveyors by focusing survey resources on facilities that have the largest number of quality concerns. We analyze the relationship between time and outcomes to measure whether the QIS is associated with changes in how well surveyor time is targeted to facilities with more quality problems

This is an evaluation of real-world implementation of the QIS with several constraints on ideal research design. The study design focused on controlling two factors that are known to impact survey results: state differences and changes over time in survey practices. It was not possible to control for the selection of surveyors or the facilities receiving a QIS survey, and the design was also constrained by limited funding and time to complete the evaluation. In general, comparisons focus on within-state differences between the QIS and Standard surveys.

Does the QIS Lead to Increased Accuracy?

Improved accuracy of quality of care and quality of life problem identification is one of the objectives of the QIS. The QIS includes substantially larger random samples of residents including 40 residents currently residing in the facility and up to 30 admissions from the prior six months. This is expected to yield more valid inferences about the care provided to residents and systems of care. Improved accuracy may also result from the Stage Investigative protocols, standardized data collection, and use of computerized algorithms to identify areas on which to focus in Stage II.

To test whether the QIS is more accurate than the Standard survey, we made site visits to a sample of 20 facilities to collect data on the quality of care provided by the facility. The sample size was determined by the time and resources available for this activity. While data were collected at the same time as the nursing home's survey, the evaluation researchers worked independently of the surveyors, collecting information on a series of Care Indicators (CIs) to assess quality in five domains: incontinence, nutrition, pressure ulcers, choice, and activities. Differences between the QIS and standard survey in how accurately they measure the care elements described in the interpretative guidelines can only be proven if the deficiencies written by the two survey types are compared to deficiencies that might be written by an independent assessment of care quality. A more accurate process would be expected to identify more of the same care problems identified by the independent

system. We used information collected as part of the site visits to address a set of research questions related to the ability of the QIS to detect quality problems compared to the Standard survey.

Methods

Our approach for investigating whether the QIS is more accurate than the Standard survey was to compare the relationship between facility quality as measured by the CIs and survey findings for QIS and Standard surveys. If the QIS is more accurate than the Standard survey, then there should be a stronger relationship between quality and deficiencies for QIS surveys than for Standard surveys.

Overall, there were 75 CIs that were included in our analyses. These included some that were previously tested and validated in the Assessing Care of Vulnerable Elders (ACOVE) project as well as some new indicators were combined to assess quality in five care areas: incontinence, nutrition, pressure ulcers, choice, and activities. The CIs that were used could be linked with specific care processes that were identified for investigation in the interpretative guidelines or critical element pathways for the specific care areas selected for investigation.

We followed very specifically defined protocols for observation and data collection, mapping CI scores to CMS guidelines for compliance, and scope and severity decisions using a set of uniform decision rules. All of the CIs use an "if-then" framework that describes the residents to whom the CI applies and the care process to be provided. A set of specific criteria were used to identify residents at risk for various quality problems, and the indicators were only scored for residents who met these criteria. The scoring system produced continuous data expressed as the number or percentage of residents that failed each CI.

The translation of CI data into Ftag statements was particularly problematic for this project since the current rules used by CMS allow considerable judgment on the part of surveyors as to when survey results raise to the level of a citation. We preferred not to depend on the expert judgment of research staff in linking CI results to probable Ftag citations and instead developed standardized rules which we believed to be consistent with the intent of the CMS regulations. The basic rule that we developed was that a resident must fail an indicator in assessment, care planning or care plan revision, and provision of care to site an Ftag. Ftags were cited as greater than isolated if more than two residents met the above criteria in specific areas of care.

The data collected on-site were used to compare the accuracy of QIS and Standard surveys. To do this, the data were aggregated across CIs into the five care areas and compared to related Ftags that were cited by the state surveys that were conducted concurrently with our site visit. CMS 2567 forms were carefully read by two independent reviewers to identify Ftags that were related only to the targeted five care areas; we did not consider Ftags that were not related to the five care areas. The expectation was that a high failure rate for the CIs in a domain would correspond to a failure to meet regulatory standards, which should be related to the Ftags cited by surveyors. Our test for whether the QIS is more accurate than the Standard survey is whether there was a stronger relationship between the CIs and survey findings for QIS surveys than for Standard surveys.

Site Visits

Site visits were made to two matched pairs (one QIS survey, one Standard survey) in each state for a total of 20 site visits. We considered a number of criteria in selecting the matched pairs, including

survey region, facility size, ownership type, survey deficiency history, and recommendations from State Survey Agency contacts. It was not possible to match on all of these criteria, but we selected pairs of facilities that appeared to be a good match based on an overall assessment of our matching criteria. We did not visit nursing homes that were undergoing a Federal Monitoring and Oversight Survey or nursing homes that State Survey Agencies asked us not to visit.

Two-person teams consisting of at least one registered nurse were used on all site visits. With the exception of one member of the team, all of the site visitors had collected data for the Formative Evaluation and were thus familiar with the project. While on-site, researchers collected information needed to calculate pass/fail rates for each of the CIs. There were three components of the data collection process: medical record review, resident interview, and observation.

- ***Medical record review:*** Medical record review included a screening tool to identify residents who had or were at risk for specified conditions, a review of diagnoses and medications that may impact a resident's condition, and a chart review investigation.

- ***Resident interviews:*** All non-cognitively impaired residents in our sample were approached for an interview, which included questions about pressure ulcers, urinary incontinence, nutrition, choices, and activities.

- ***Resident Observations:*** Four types of resident observations were completed during the on-site visit: Continuous observations for Toileting and Positioning, 60-minute Behavioral Observations, Dining Observations, and ADL-Choice observations.

Information was collected from a sample of residents who had been in the nursing home for 12 months or less and who had or were at risk for one or more of the domains of interest. The sample consisted of a minimum of ten residents with each condition, at risk for the condition, or having a history of the condition. In most cases, residents had more than one condition resulting in a sample size of between 12 and 20 residents per site.

Results

In general, we did not find any differences in accuracy for the QIS and Standard surveys.

- ***The QIS and Standard survey samples were comparable with respect to overall quality and survey deficiencies cited.*** The two groups were also similar with respect to the frequency of Ftag citations of a scope beyond isolated. These findings suggest that the matching criteria used to select facilities for the site visits worked reasonably well.

- ***The overall failure rate on the CIs was high.*** The overall fail rate across all care areas was 44 percent for the Standard sample and 45 percent for the QIS sample. The high CI fail rate in both QIS and Standard survey facilities supports the argument that many Ftags could have been written in most facilities even if rigorous standards were used to convert quality findings into deficiency statements. Across nursing homes, there was significant variability between CI fail rates for all care areas that provided the opportunity to judge how the two survey types discriminated quality with the Ftag citation system.

- ***Overall, the relationship between quality and survey deficiencies was low.*** We found a positive but low correlation between the overall number of related Ftags and quality as measured by the CI fail rate for both Standard and QIS surveyed nursing homes. Neither QIS nor Standard surveys consistently documented that providers failed to implement many of the care indicators recommended in the investigative protocols. Some recommended quality measures were never or rarely documented by either survey team in an Ftag statement despite the fact that the majority of residents who were eligible for the care described in the guidelines were found in this evaluation to not receive that care.

- ***There was no evidence of a stronger relationship between quality and deficiencies for QIS surveys.*** We found that there were no differences in the ability of the QIS and Standard surveys to detect quality problems as measured by the explicit quality assessment protocols used by the research teams. The correlation between Ftag citation rate and overall indicator fail rate across all care areas was positive but relatively low for both types of surveys. It was higher for Standard surveys (0.34) than for QIS surveys (0.19).

- ***Findings suggested that more survey deficiencies with scope greater than isolated could have been cited for both QIS and Standard surveys.*** We found that over fifty percent of the facilities could have been cited for a scope greater than isolated in all care areas, with the exception of activities, even when a rigorous standard was used to translate the CI data into deficiency statements. Both types of surveys failed to detect more than isolated problems in many facilities.

- ***There was no evidence that the QIS was more accurate with respect to survey deficiencies with scope greater than isolated.*** The CIs identified 29 occasions that would justify an Ftag greater than isolated across the Standard survey nursing homes and 31 opportunities for QIS nursing homes. The Standard survey teams wrote greater than isolated Ftags in 15 out of these 29 opportunities (52 percent) vs. 11 out of the 31 opportunities (35 percent) for QIS surveys.

- ***Both types of surveys failed to detect many residents with poor pressure ulcer and weight loss outcomes.*** We developed a set of rules for converting the CI data into citations that could have been made beyond G for weight loss and pressure ulcers. We identified seven different QIS nursing homes and five different Standard nursing homes could have been cited for a G or higher pressure ulcer citation. All ten QIS nursing homes and eight Standard nursing homes could have been cited for a G or higher citation in nutrition. Both types of surveys failed to detect many residents who have poor pressure ulcer and weight loss outcomes and who also receive poor care according to multiple data sources.

- ***The QIS may be better at citing appropriate G-level deficiencies, but the available sample size is insufficient to draw any conclusions.*** There were a total of two Ftags cited at the G-level for nutrition and two cited at G-level or above for pressure ulcers. All the citations were by QIS teams in one state and took place in just two different nursing homes. Given the small sample size, it is not possible to draw any conclusions from these findings, but they suggest that the QIS may be better at citing appropriate G-level citations.

Implications

We did not find evidence that the QIS is more accurate than the Standard survey, despite the fact that it has started the process of making the survey process more specific and focused with its Stage I protocols and automated data entry system. We qualify these findings by noting that comparisons between the QIS and Standard surveys were limited by a small sample size; thus the data we provide are best used for survey improvement purposes rather than to inform a decision about what type of survey process to use. That said, we do not believe that a larger sample size would produce dramatically different results until further refinements are made in the basic concepts that underlie the QIS and which make it different from the Standard survey process.

Based on the data collected in the formative evaluation and this field test evaluation, we believe that the best explanation for the lack of differences between the two survey methods is related to two issues: 1) the specificity of the investigative guidelines and the critical element pathways, and 2) how feasible or "user friendly" the critical element pathways and interpretative guidelines are to implement. The various investigative documents used by both survey types vary in specificity such that there is much interpretation left to the discretionary judgment of surveyors. Despite this evaluation's small sample size, the recommendations for correcting these specificity and feasibility problems are clear.

Does the QIS Result in Improved Documentation of Survey Deficiencies?

Because of the larger samples, more structured data collection, and the automated computer processes used to organize survey findings, the QIS was expected to lead to improved documentation quality. The Critical Element Pathways, intended to assist surveyors in their Stage II information gathering, were expected to lead to the citation of more related deficiencies.

Methods

To investigate whether the QIS results in improved documentation of survey deficiencies, we conducted a content review and analysis of a sample of draft statements of deficiencies from CMS 2567 forms. Pairs of survey citations (one from a QIS survey and one from a Standard survey) were reviewed and scored by trained nurse reviewers using a set of review protocols that were developed based on the CMS Principles of Documentation, the State Operations Manual, and input from CMS survey and certification staff at both the Central Office and Regional Offices. The protocol was intended to capture four separate dimensions of survey deficiency documentation, including:

- Quality of the evidence that justifies or substantiates the citation
- Accuracy of the scope rating
- Accuracy of the severity rating
- The extent to which surveyors issue the related process tags when an outcome tag is cited

Rather than select *complete* 2567 forms for review, we selected specific Ftags from the draft forms, in order to analyze matched pairs of Ftags cited on standard and QIS surveys. The sampling strategy was

driven to a large extent by the available sample of Ftags for which there were pairs of deficiencies within State (for QIS and Standard surveys) at similar levels of scope and severity.

In order to capture surveyor findings as close to the time that impressions about facility quality and compliance with federal LTC requirements were formulated by the surveyors, we chose to use the "draft" 2567s, or initial reports of survey findings, in this analysis. These are survey findings that have not yet undergone supervisory review. The decision to review draft 2567s was the result of careful consideration by the research team and CMS of how best to measure the difference between the standard and QIS documentation quality. The QIS was not designed to impact the supervisory/office review process, and it was decided that a better test of whether the QIS leads to improved survey documentation would use the version of the 2567 that is produced by the survey team, before any supervisory/office review.

We requested that each State send us draft 2567s on an ongoing basis for both standard and QIS surveys. We trained a team of two researchers who reviewed a sample of the 2567s using standardized review protocols, and scored the 2567s and associated Ftags according to the quality of documentation. The Ftags were reviewed blind as to whether they were from a QIS or Standard survey.

These data were analyzed to determine whether the QIS does in fact produce better documentation than the Standard survey process. Two major limitations of the analysis are the lack of formal tests of inter-rater reliability and the fact that each Ftag was reviewed by only one reviewer. These limitations were driven by the time and resources available for this activity. The procedures for establishing inter-rate reliability between the reviewers were really informal practice sessions on a handful of tags, followed by discussions to resolve differences and subsequent changes to the protocols and guidance.

130 Ftags selected from the top 15 deficiencies in four demonstration states were rated for documentation adequacy by two reviewers using a research protocol. (Kansas was excluded for technical reasons.) Within each deficiency area, the tags were selected from QIS and Standard surveys in equal numbers and roughly the same scope and severity. The reviewers were both nurses formerly employed as long-term care surveyors. The review protocol had four dimensions: quality of the evidence that justifies a citation; accuracy of the scope rating; accuracy of the severity rating; and the extent to which surveyors issue the related process tags when an outcome tag is cited.

Results

Although there were some differences across the dimensions examined, overall there was essentially no evidence that the QIS leads to higher quality deficiency documentation. Nor was there any evidence that the QIS led to an overall increase in the citation of Related Ftags:

- ***Standard surveys were more likely to include both a deficiency statement and a related outcome.*** Overall, 33 percent of Standard survey Ftags reviewed were noted to include both a deficient statement and a related outcome, while 21 percent of QIS Ftags reviewed met this standard. QIS survey *process* deficiencies, such as assessment (F272) and care planning (F279) deficiencies, were more frequently accompanied by their related outcome tags than were Standard survey deficiencies, but, for outcome deficiencies (e.g., pressure ulcer

development, F314), Standard surveys were more frequently accompanied by related process deficiencies than were QIS outcome deficiencies.

- ***QIS deficiencies tended to cite more types of evidence than Standard deficiencies.*** QIS Ftags reviewed cited as many or more types of evidence in general, for both process and outcome tags.

- ***There was little difference with respect to the quantity of evidence cited.*** There were differences across States. California and Ohio QIS surveys referenced a higher number of data points than their Standard survey counterparts, while fewer data points were cited on Louisiana QIS surveys.

- ***There was no evidence that the QIS was associated with citation of additional related Ftags.*** The review of CE Pathways did not reveal significant differences between the "related Ftags" cited on QIS vs. Standard surveys. It does appear that the ADL Critical Element Pathway consistently guided QIS surveyors to cite a higher average number of related deficiencies; however, no other distinct pattern emerged from this review to support that the availability of the CE Pathways in the QIS survey influenced deficiency citations.

Implications

Given the initial difficulty in achieving inter-rater reliability on this aspect of the 2567 review, and the limited sample of reviewed tags in this component of the review, the CE Pathway review findings should be interpreted with caution. While there is no concrete evidence that a reasonable level of inter-rater reliability was achieved prior to the review nor sustained during the review, the reviewers were experienced surveyors who participated in the development of the review protocol and guidance. The lack of a systematic differences in documentation quality may reflect the variable knowledge and skill of the surveyors under both the QIS and Standard survey, which likely influences both the decision to cite and the supporting documentation

How Does the Time Required to Complete the QIS Compare to the Time Required for the Current Survey?

A major evaluation question is whether the QIS takes longer than the current survey process. The formative evaluation was used to identify a number of ways to streamline the QIS to reduce survey completion times. For national implementation, it is important that the QIS be resource neutral, at least in the aggregate across states. Increased time requirements may be problematic given limited survey budgets.

Methods

The data source for these analyses is Form CMS-670, the Survey Team Composition and Workload form. Surveyors use this form to record the amount of time that members of the survey team spend on pre-survey preparation, on-site, travel, and off-site report preparation. For these analyses, we considered pre-survey preparation, on-site, and off-site report preparation time, but not travel hours. Our analyses emphasize a time measure that includes only the time required to complete the survey itself and that does not include time associated with post-survey follow-up activities such as ensuring that facility plans of correction have been implemented. We believe that this allows for the most

accurate analysis of the time associated with QIS surveys. However, because the time associated with survey follow-up activities may be indirectly related to the QIS (e.g., if this follow-up time is related to the number of deficiencies and the number of deficiencies is higher for QIS surveys), for some analyses, we used a time specification that also included the time associated with post-survey follow-up activities.

We estimated the time requirements for the QIS by comparing the change in survey completion times for QIS surveys and Standard surveys conducted during the same time period to the previous survey at the facility, which was completed using the Standard survey process at all facilities. We used a "difference in differences" model in which we compared the change in survey completion times for facilities that had a QIS survey to the change in time for facilities that had a Standard survey during the QIS demonstration. This analysis allowed us to take account of factors other than the QIS that affected survey completion times that would be missed in a simple pre-post comparison,

Results

- ***Results varied across States.*** While we used a variety of analyses to examine the time requirements of the QIS, in most cases, the most appropriate analysis was a comparison of survey completion times for the QIS and the prior survey, which was completed using the Standard survey process. The pre-post comparison showed that results varied across States.

    - For three states (California, Kansas, Ohio), the QIS took longer than the prior Standard survey at the same facilities—the pre-post differences were especially large in California and Kansas. In California, the QIS survey required 68 more hours than the prior survey at the facility, an increase of 46 percent. In Kansas, the QIS required 62 more hours than the prior survey, a 43 percent increase. In Ohio the difference was small; the QIS took an additional 4.55 (3.6 percent) hours, a difference that went away entirely for surveys completed after the changes recommended as part of the Formative Evaluation were implemented

    - In Connecticut and Louisiana, the QIS was completed more quickly than the prior survey at the facility. In Connecticut, the QIS took about nine hours less than the prior survey. In Louisiana, the difference was very large. The QIS took 46 hours less than the prior survey at the facility. There was a large decrease in time for both Standard surveys in the State that may reflect disruptions to the survey process resulting from Hurricane Katrina.

    - Inclusion of the time associated for post-survey follow-up activities (e.g., to ensure compliance with plans of correction) did not change the basic conclusions of our analysis. Results varied across the five states, with QIS surveys taking much longer in California and Kansas, slightly longer in Ohio, and less time in Connecticut and Louisiana.

- ***Exclusion of outliers does not change basic conclusions regarding QIS completion time.*** There were some QIS surveys that took an extraordinarily long time to complete, in some cases 200 or more hours. All but one of these surveys was in California or Kansas. The explanation for the high completion times varied. Some of these surveys were among the first QIS surveys conducted in the state; for others there were extenuating circumstances that

affected the time needed to complete the survey. Survey times were extremely high for QIS surveys completed in California's East Bay region, in which surveyors had difficulties becoming compliant with QIS processes. For other high time outliers, the time required to complete the QIS was not much higher than the time required to complete the prior survey, likely due to a large number of deficiencies cited on both surveys.

- ***The changes to the QIS implemented after the formative evaluation reduced QIS time requirements.*** The changes to the QIS implemented after the formative evaluation appeared to lead to modest reductions in the time required to complete QIS surveys.
    - In Connecticut, the mean time for QIS surveys was 126 hours for surveys started before May 31, 2006, compared to 105 hours for surveys started after implementation of the formative evaluation changes.
    - For Kansas, mean survey completion times were almost identical for the two periods, but median time was 20.5 hours lower for surveys that started after implementation of the formative evaluation recommendations.
    - There were only six QIS surveys conducted in Louisiana before May 31, but both the median and mean times were higher for these surveys than for surveys that were started on May 31 or later.
    - In Ohio, average survey completion time was 133.9 hours for the earlier group of surveys, compared to 125.6 hours for surveys that applied the changes made following the formative evaluation.
    - Across all states, the average overall survey completion time was 133.9 hours for the earlier group of surveys, compared to 125.6 hours for surveys that reflected the changes made following the formative evaluation.
    - Note that California did not begin doing QIS surveys until June 2006, which was after implementation of the formative evaluation changes.
- ***There was some evidence of a learning curve.*** We anticipated that, as they became familiar with the QIS process, surveyors would be able to complete the QIS more quickly We found some evidence of a learning curve in the two states (Connecticut and Ohio) that had stable survey teams throughout the demonstration period. These results suggest that the comparisons of QIS time that only include the subset of surveys completed after implementation of the formative evaluation recommendations likely gives the best estimates of the long-term impact of the QIS on survey completion times. A limitation of these analyses is that the effects of a potential learning curve are confounded with other changes that occurred during the demonstration period such as the changes to the QIS made after the formative evaluation.

Implications

The experiences of Connecticut and Ohio suggest that the there is nothing inherent about the QIS process that suggests that the QIS survey cannot be completed in the same amount of time as

Standard surveys. In Connecticut, QIS surveys appeared to take less time than Standard surveys. In Ohio, QIS surveys completed after implementation of changes to the QIS following the formative evaluation took about the same time as the prior survey at the facility. Based on the experiences of these two states, we would conclude that concerns about the time required to complete the QIS survey are unfounded, as there is nothing to indicate that the QIS takes any longer than the Standard survey process.

The experiences of California and Kansas, however, lead to the opposite conclusion, suggesting that it is not automatically the case that the QIS can be completed as quickly as Standard surveys. In Kansas, QIS surveys took an average of 207 hours to complete, 62 hours more than the prior survey. The time differences that we observed in the state cannot be attributed to a learning curve, outliers, or other factors that may not affect long-run survey time requirements. Something about the way that QIS surveys were conducted in the State led to the QIS surveys taking much longer than Standard surveys. In California, QIS surveys also took considerably longer to complete than the prior survey. This was the case for both the San Diego and East Bay districts, reflecting the difficulties that the State experienced in conducting QIS surveys.

Given our mixed findings with respect to QIS completion times, if the QIS is expanded to additional states, it is difficult to know whether these states' experiences will be more like those of Connecticut and Ohio or those of California and Kansas. As a result, while we do have conclusions about how long QIS surveys took to complete in each of the demonstration states, we do not offer conclusions about the time requirements of the QIS in other states. The likelihood is that there will be some states for which the QIS does not take any longer to complete than Standard surveys and others that struggle to implement the QIS and find that it does take longer. In any case, the results for Connecticut, Louisiana, and Ohio lead us to conclude that it is certainly possible for states to implement the QIS in a resource-neutral way, even taking account of any additional post-survey follow-up activities that may result from additional survey deficiencies cited on QIS surveys

It is important to keep in mind that, in order to be budget neutral, we do not require that the QIS take the same amount of time or less in every state. The experiences of the five demonstration states suggest that the QIS may be resource neutral in the aggregate. It may be that some reallocation of survey and certification resources would be required if the QIS were implemented in other states, with additional resources given to states for which the QIS takes longer than Standard surveys. It was beyond the scope of this evaluation to address these types of issues.

How Does the QIS Impact the Number and Types of Deficiencies That Are Cited?

While increases in survey deficiencies are not among the stated objectives of the QIS, we examined the impact of the QIS on the number, scope/severity, regulatory care areas, and individual F-tags cited by survey teams. We also examined whether the QIS leads to a more comprehensive assessment of all regulatory areas. We estimated the impact of the QIS on these outcomes using a combination of pre-post and difference-in-difference analyses.

Methods

We used data from the CMS Online Survey Certification and Reporting (OSCAR) system to measure survey outcomes and Form CMS-670 data to measure the impact of the QIS on survey outcomes. We

examined the number of deficiencies, the number of deficiencies for actual harm and above (G-level and above, and the regulatory care areas cited by QIS surveys. Our data do not include complaint surveys and we considered only deficiencies that resulted from health inspections.

As we did with the analyses of QIS completion time, we used a "differences-in-differences" model to estimate the impact of the QIS on survey outcomes. Using the difference-in-differences model, we can estimate the impact of the QIS on survey completion time for the other states as well, allowing us to adjust for factors that may have affected survey outcomes across both standard and QIS surveys

Results

- ***The QIS was associated with an increase in the number of survey deficiencies:*** Using the difference-in-differences model to account for general time trends, we estimate that the QIS was associated with 1.6 additional deficiencies in California (a 14 percent increase), 0.6 fewer deficiencies in Connecticut (a 9 percent decrease), 9.4 additional deficiencies in Kansas (a 99 percent increase), 1.9 additional deficiencies in Louisiana (a 29 percent increase), and 2.4 additional deficiencies in Ohio (a 52 percent increase).

- ***The QIS was associated with an increase in G-level deficiencies:*** We also examined the impact of the QIS on deficiencies cited at the G-level or above (G, H, I, J, K, L). The rate of G-level deficiencies was relatively small for both types of surveys, but the QIS was associated with large increases in Kansas, and Ohio and a large decline in Connecticut. There was a slight increase in California and relatively little change in Louisiana.

- ***The QIS was associated with an increase in the regulatory care areas cited***: One of the objectives of the QIS is to comprehensively review a wide range of regulatory care areas. In all five states, there were more regulatory care areas cited on QIS surveys than on the prior survey at the facility. For all regulatory care areas except for infection, facilities were more likely to receive a deficiency with the QIS survey than with their prior survey. For some regulatory care areas (resident rights, quality of life, dietary care, physician services, dental care, physical environment), the differences were substantial.

Implications

The analysis provides strong support for the hypothesis that the QIS leads to an increase in the number of survey deficiencies and an increase in the regulatory care areas that surveyors cite, supporting expectations about the QIS. These are an important findings given the studies by the General Accounting Office (GAO) and Office of the Inspector General (OIG) that have found that the Standard survey under reports deficiencies, harm-level deficiencies, quality of life, resident rights, and dental deficiencies. As a practical matter it would be difficult to implement any system that results in several fold increases in deficiencies, but this was not in general the case although the increase observed for Kansas QIS surveys may be a reason for concern.

A potential limitation of this analysis is that we are unable to control for surveyor quality. QIS surveyors were chosen to participate in the demonstration because of their experience. It may be that the QIS teams have higher citation rates than other survey teams, and that this may explain some of the increase in survey deficiencies that we observed for QIS surveys.

Does the QIS Improve Surveyor Efficiency?

One of the objectives of the QIS is to improve the efficiency of surveyors by focusing survey resources on facilities that have the largest number of quality concerns. The two-staged process focuses surveyor resources on areas identified as problematic in Stage I and permits bypassing the second stage investigation for potential problems if these concerns do not exceed thresholds established by prior research. If the QIS is successful in achieving the objective of increased efficiency, then there should be a stronger relationship between survey time and survey outcomes for QIS surveys than for Standard surveys.

We examined the relationship between the time required to complete surveys and survey outcomes for QIS and Standard surveys. Further, we examined whether the QIS was associated with a change in this relationship that suggests that the QIS is more effective than the Standard survey in terms of focusing surveyor resources on the most problematic facilities.

Methods

To examine whether the QIS was associated with an increase in surveyor efficiency, we estimated a series of regression models that included interaction terms for the number of deficiencies and the type of survey (QIS, prior survey at QIS facilities, Standard survey during demonstration period).

Results

We found that, for both QIS and Standard surveys, there is a strong relationship between the total number of deficiencies and survey completion times. The overall correlation between time and deficiencies was 0.56 for Standard surveys (including both pre-QIS surveys and Standard surveys conducted during the demonstration period. Within individual states, this correlation ranged from 0.39 in Connecticut to 0.77 in Louisiana. For QIS surveys, the correlation was 0.73 across all QIS surveys. The within-state correlations were lower (ranging from 0.53 in California to 0.75 in Louisiana).

The regression models showed that number of deficiencies and facility size were strong predictors of survey completion time, while G-level deficiencies were typically not significantly related to survey completion time. Regression results showed that, while there was a strong relationship between time and deficiencies for QIS surveys in Connecticut, Louisiana, and Ohio, the only state in which the QIS was associated with an increase in surveyor efficiency (as measured by the relationship between time and survey outcomes) was Ohio. For Ohio, the coefficient on total deficiencies for QIS surveys was much higher than the coefficient on total deficiencies for pre-QIS and Standard surveys, suggesting that the QIS led to improved surveyor efficiency.

The limited number of QIS surveys available for the regression models in California, Kansas, and Louisiana is an important limitation of this analysis, as it restricted our ability to examine subsets of QIS surveys such as those completed after an initial learning process or those conducted after implementation of the changes to the QIS that followed the formative evaluation. The patterns that we observed in Ohio suggest that the QIS has the potential to improve surveyor targeting to facilities with the most quality problems, but the experiences of the other states suggests that this need not be the case.

Implications

These results do not appear to be consistent with the expectation for improved targeting and efficiency for the two-staged QIS process. The only state consistent with this expectation was Ohio, which had a lower correlation between Standard survey time and deficiencies than the other states and far more opportunity for improvement. The small sample size available for these analyses limits the conclusions that we can draw for California, Kansas, and Louisiana.

Conclusions

The results of the evaluation were mixed and do not lead to firm conclusions about the effectiveness of the QIS.

- ***Does the QIS lead to increased accuracy?*** Based on the relationship between survey findings and a set of care indicators intended to measure the quality of care provided by nursing facilities, we did not find evidence that the QIS was more accurate than the Standard survey. Our results suggested that more survey deficiencies with scope greater than isolated could have been cited for both QIS and Standard surveys. Ultimately, under both types of surveys, there appears to be a great deal of surveyor discretion and judgment that influences the decision to cite.

- ***Does the QIS result in improved documentation of survey deficiencies?*** We found essentially no differences in documentation quality associated with the QIS, although inter-rater reliability concerns limit the strength of this conclusion.

- ***How does the time required to complete the QIS compare to the time required for the current survey?*** Results indicate that there is nothing inherent in the QIS which indicates that it cannot be resource neutral. We found that the QIS took considerably longer to complete than Standard surveys in two of the five demonstration states; two states consumed about the same amount of time and one state's time was open to different interpretations.

- ***How does the QIS impact the number and types of deficiencies that are cited?*** The results of this evaluation clearly indicate that the QIS cites more deficiencies, at higher levels, and more in these usually under-cited areas.

- ***Does the QIS improve surveyor efficiency?*** The correlation between time and deficiencies was higher for QIS surveys than for Standard surveys. Ohio was the only state for which the QIS was associated with an increase in surveyor efficiency.

A number of recommendations for improving the QIS emerged from the field work conducted as part of the summative evaluation and the earlier formative evaluation. These recommendations focused on ways to improve the accuracy of the QIS.

- ***Improve specificity and usability of investigative guidelines.*** The care elements that are recommended for investigation in existing interpretative guidelines and critical element pathways should be modified so that they are consistent with the principles that guide reliable and accurate measurement.

- ***Provide competency-based training for surveyors to improve consistency.*** Provide survey staff with training in the principles of reliable measurement and document that the trained surveyors can use the investigative protocols to produce consistent and accurate quality conclusions.

- ***Evaluate how well the QIS Stage I and unstaged protocols identify problem areas that should be investigated in Stage II.*** If the QIS is accurately detecting areas for investigation, then quality measures for facilities that are flagged for an investigation should be different and worse than the measures for facilities that are not flagged. We did not find these differences in our evaluation of QIS accuracy, suggesting that the question of whether Stage I accurately identifies areas in which there are potential quality problems and which are thus the best targets for Stage II investigations is relevant.

- ***Increased structure in Stage II to make decision making more explicit in determining noncompliance, scope, and severity.*** Despite the structure of Stage I that ensures that surveyors conduct a more comprehensive survey and utilizes more information from residents and families, the process becomes increasingly subjective in Stage II and during certain facility-level tasks. Of highest priority is the development of additional CE pathways for the many important care areas where these do not exist. A second priority is to improve the integration of the CE pathways into the Stage II investigation.

This report also includes a chapter "Quality Indicator Survey Demonstration: The Big Picture" that was written by Andrew Kramer, one of the developers of the QIS. This chapter summarizes findings from the University of Colorado's work in developing the QIS and recommendations for future development work. We requested that Dr. Kramer write this chapter because of the many insights that he has gained during the development of the QIS, but it is not part of the independent evaluation of the QIS conducted by Abt Associates and Vanderbilt University.

1. Introduction and Overview of Report

1.1. Overview

The QIS is a revised long-term care survey process that was developed under the Centers for Medicare & Medicaid Services (CMS) oversight through a multi-year contract. It was designed as a staged process for use by surveyors to systematically and objectively review all regulatory areas and subsequently focus on selected areas for further review. The QIS was developed to:

- Improve consistency and accuracy of quality of care and quality of life problem identification using a more structured process;
- Comprehensively review the full range of regulatory care areas within the current survey resources;
- Enhance documentation by organizing survey findings through automation; and
- Focus survey resources on facilities with the largest number of quality concerns.

The QIS provides a structure for an initial review of larger samples of residents based on the Minimum Data Set (MDS), observations, interviews and medical record reviews. Utilizing onsite automation, survey findings from the first stage are combined to provide rates on a comprehensive set of Quality of Care Indicators (QCIs) covering all resident- and facility-level federal regulations for nursing homes. The second stage then provides surveyors the opportunity to focus survey resources on further investigation of care areas where concerns exist. Although the survey process has been revised under the QIS, the federal regulations and interpretive guidance remain unchanged.

1.1.1. QIS Demonstration Overview

After a research phase, during which the basic objectives, concepts, processes and protocols were developed, the QIS was alpha and beta tested using mock surveys, with subsequent modifications and refinements. However, the QIS had never been tested using surveys of record, nor had it undergone large-scale testing in multiple nursing facilities. In 2005, CMS launched the QIS Demonstration to evaluate the QIS on a larger scale using surveys of record. By implementing the QIS with surveys of record (rather than mock surveys), the QIS surveyors are required to defend their findings under realistic conditions, with the same pressures applied to surveyors using the current survey process. The demonstration and evaluation is being conducted in five states, California, Connecticut, Kansas, Louisiana and Ohio. Some facilities in Demonstration states are being surveyed using the QIS as the survey of record; however, most facilities in these states are surveyed using the current survey process. Surveyor teams from participating states were trained on the use of the QIS protocols and software in two phases, the first beginning in September 2005 and the second in March 2006. Connecticut, Kansas and Ohio participated in the first phase, and California and Louisiana took part in the second phase.

Participating survey teams in each state consist of no fewer than four surveyors. Training included classroom sessions, training surveys, and surveys of record (SRs). Training staff from UCHSC led the classroom sessions, and attended the training survey and first survey of record to provide ongoing training and oversight. In addition, UCHSC evaluation staff attended the first two SRs to assess surveyor compliance with the QIS and provide correction/guidance as needed. In the event that a team did not demonstrate compliance with the QIS protocols upon completion of two SRs, UCHSC

NURSING HOME DECISIONS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES'S DEPARTMENTAL APPEALS BOARD, 2007

Toby S. Edelman
Senior Policy Attorney
Center for Medicare Advocacy, Inc.

May 2008

Strangulation death on bedrail
$4050 civil money penalty

Rehabilitation & Care Center of Jackson County, CR1590: Between November 2001 and March 2002, an 88-year-old resident at the Illinois nursing home fell numerous times from her bed while her bed's side rail was raised. On March 12, 2002, she "was found on the floor [uninjured] with her back against the bed, holding onto one of the half side rails with both hands, with her neck wedged between the half side rail and the mattress." A week later, on March 19, she was found in the same position, "on the floor next to her bed with her head wedged between the half side rail and the mattress," but this time, without pulse, respiration, and blood pressure. She had died of accidental strangulation. The Centers for Medicare & Medicaid Services cited the facility with failure of supervision, at the immediate jeopardy level, and with failure of assessment, at a non-jeopardy level. The Administrative Law Judge sustained both deficiencies and both remedies, a $3050 per instance civil money penalty for the supervision deficiency and a $1000 per instance civil money penalty for the assessment deficiency.

Leg amputation following failure to follow physician's treatment orders
$7500 civil money penalty

Morrisons Cove Home, CR1581: A resident was admitted to a Pennsylvania nursing home May 24, 2004 for short-term rehabilitation following surgery for a fractured ankle. The nursing home failed to bring her to her surgeon's office for a follow-up visit on June 2. When the resident saw her surgeon on June 11, the surgeon determined that her wound was not healing correctly. He referred the resident to a wound specialist, who debrided the wound and ordered a culture, which identified an infection. The attending physician ordered that the resident's wound be monitored for infection and treated daily and that the resident be given an antibiotic. The staff failed to follow the physician's orders. On June 17, the resident was hospitalized; her leg was subsequently amputated. The Centers for Medicare & Medicaid Services cited the facility with a deficiency for failure to meet professional standards of care and imposed a per instance civil money penalty of $7500. The Administrative Law Judge sustained the deficiency and the remedy.

* * *

These are the facts, and enforcement consequences, in two of the 85 cases decided by the Department of Health and Human Services's Departmental Appeals Board in 2007. This report discusses all 85 decisions that were issued by the DAB in 2007 – 66 in the Civil Remedies Division and 19 in the Appellate Division.

TABLE OF CONTENTS

PREFACE 1

EXECUTIVE SUMMARY 2

BACKGROUND 4

ANALYSIS 8

The Civil Remedies Division 8

The Appellate Division 19

DISCUSSION AND RECOMMENDATIONS 27

CONCLUSION 28

PREFACE

The federal regulatory system for nursing homes has three distinct components – the standards of care, called Requirements of Participation, that facilities must meet in order to provide high quality of care and quality of life to residents; the public survey process, which determines whether facilities comply with the federal standards of care; and the enforcement system, which imposes sanctions against facilities that are cited with deficiencies for noncompliance with federal standards. Nursing homes that voluntarily choose to be eligible to receive federal reimbursement under the Medicare or Medicaid programs, or both, agree to this comprehensive oversight structure.

Over the years, considerable public attention has been focused on whether the enforcement system is effective in ensuring that facilities provide residents with the appropriate care they need and are guaranteed by the Nursing Home Reform Law. Advocates for residents often contend that the system is too tolerant of poor care. The nursing home industry argues that the enforcement system is overly strict and punitive. For the first time since the 1987 Reform Law was enacted, Congress is considering amendments to the law's enforcement provisions.

Prior analyses have looked at deficiencies – how many are cited, how serious they are, whether survey agencies accurately code the seriousness of facilities' failures in care. But deficiencies are not the end point of the enforcement system; they are only the public statements of noncompliance with federal standards of care on which actual enforcement – the imposition of sanctions – is based.

This report is the first report to look at the enforcement actions taken against nursing homes that facilities appealed through the federal administrative process. It reviews all 85 decisions issued by the U.S. Department of Health and Human Services's Departmental Appeals Board in 2007 – 66 decisions by Administrative Law Judges at the Civil Remedies Division, 19 decisions by three-judge panels at the Appellate Division.

This report provides information about which deficiencies and remedies facilities appealed and how the administrative process dealt with those appeals – how the nursing home Requirements of Participation are really enforced. We hope this report will help inform public policy.

 ©The Center for Medicare Advocacy

EXECUTIVE SUMMARY

Strangulation death on bedrail
$4050 civil money penalty

Rehabilitation & Care Center of Jackson County, CR1590: Between November 2001 and March 2002, an 88-year-old resident at the Illinois nursing home fell numerous times from her bed while her bed's side rail was raised. On March 12, 2002, she "was found on the floor [uninjured] with her back against the bed, holding onto one of the half side rails with both hands, with her neck wedged between the half side rail and the mattress." A week later, on March 19, she was found in the same position, "on the floor next to her bed with her head wedged between the half side rail and the mattress," but this time, without pulse, respiration, and blood pressure. She had died of accidental strangulation. The Centers for Medicare & Medicaid Services cited the facility with failure of supervision, at the immediate jeopardy level, and with failure of assessment, at a non-jeopardy level. The Administrative Law Judge sustained both deficiencies and both remedies, a $3050 per instance civil money penalty for the supervision deficiency and a $1000 per instance civil money penalty for the assessment deficiency.

These are the facts, and enforcement consequences, in one of the 85 cases decided by the Department of Health and Human Services's (HHS) Departmental Appeals Board (DAB) in 2007. The 85 decisions address survey deficiencies cited in nursing homes in 27 states. Sixty-six of the decisions were issued by Administrative Law Judges (ALJs) of the Civil Remedies Division; 19 decisions, by three-judge panels of the Appellate Division.

The 71 cases that reached the merits[1] addressed serious failures in care – elopements, amputations of limbs, development of avoidable pressure sores, failure to give prescribed medications, overmedication, and thirteen deaths.[2] The Centers for Medicare & Medicaid Services's (CMS) decision to cite deficiencies and impose remedies was upheld in 66 of the 71 cases, or 93%. More than half the decisions at the Civil Remedies Division level, and nearly three-quarters of the decisions at the Appellate Division, involved the most serious category of deficiencies, which are called "immediate jeopardy" deficiencies. Most of the decisions by the DAB involved only one or a small number of residents.

Most of the cases imposed civil money penalties (CMPs), usually at the low or lowest end of the permissible range of per day CMPs. Only 11 of the 71 decisions reaching the merits (seven at the

[1] Fourteen decisions did not reach the merits – 13 at the Civil Remedies Division, and one at the Appellate Division. At the Civil Remedies Division, Administrative Law Judges dismissed seven cases when CMS rescinded all of the remedies prior to the hearing; three appeals were untimely filed; one case raised unappealable issue, the effective date of a facility's recertification; one facility withdrew its appeal; and one case involved the facility's lack of authority to challenge the amount of a per instance civil money penalty. The Appellate Division affirmed an ALJ's dismissal of an untimely appeal.

[2] The ALJ rejected the deficiencies in two cases involving a resident's death and found the facility in substantial compliance. In 11 cases, the deficiencies were sustained. In one of the 11 decisions, although the ALJ did not record that a resident died, the resident's death was identified in the Appellate Division decision, issued in April 2008, which affirmed the ALJ's decision.

Civil Remedies Division, four at the Appellate Division) imposed CMPs exceeding $100,000. Only two of the 11 cases sustaining the deficiencies that involved a resident death sanctioned the facility with a CMP exceeding $100,000; CMPs in the 11 death cases ranged from $4050 to $269,950.

In 2007, CMS won, in whole or significant part, 48 of 53 appeals that were decided on their merits in the Civil Remedies Division, a 90% success rate; CMS won all 18 cases decided on the merits by the Appellate Division, a 100% success rate.

Recommendations

The regulatory system, unchanged for more than a decade, needs to be updated. A stronger and faster enforcement response is needed to the serious noncompliance that is cited. CMS must impose remedies for the existence of deficiencies, not just for facilities' failure to correct deficiencies. Fines must be increased to reflect more accurately the seriousness of the harm that is identified. New guidance to states should explain how to identify the appropriate duration of noncompliance. New federal remedies are needed to respond more quickly and appropriately to failures in care.

In addition, more public information is needed about the survey and enforcement systems and about the appeals process.

At present, there is little information available to the public about enforcement actions taken against facilities that are cited with deficiencies. CMS does not publicize its enforcement activity, either at the time of imposing remedies against a specific nursing home or in a monthly, quarterly, or annual report. CMS's nursing home information website, *Nursing Home Compare*, identifies the number of deficiencies cited against facilities over a three-year period, but it identifies deficiencies solely by the regulatory provision that is cited. The website does not describe what specific problems surveyors actually found and why surveyors cited the particular deficiency. There is no link to the federal survey form, CMS 2567. In addition, *Nursing Home Compare* does not include any information about enforcement actions.

CMS also does not publicize any information about facilities' administrative appeals – their number, substance, or outcome – and it should.

 ©The Center for Medicare Advocacy

BACKGROUND

In order to understand why the Departmental Appeals Board (DAB) issued only 85 decisions in 2007, when there are 15,000 nursing homes nationwide and the overwhelming majority of facilities are cited with deficiencies in their annual surveys, it may be helpful to understand the federal survey and enforcement systems and state licensure rules.

The federal survey process

Each year, the 15,000 nursing homes that participate in the Medicare or Medicaid programs, or both, are required to have a publicly-conducted survey to determine their compliance with federal law. Surveys are conducted by state survey agencies, which are usually located in the state department of health, under contract to the federal Centers for Medicare & Medicaid Services (CMS). Additional surveys may be conducted at any time in response to a complaint by a resident, family member, or other person, or an incident that is self-reported by the facility.

Surveyors identifying noncompliance with federal Requirements of Participation cite nursing homes with deficiencies, classifying the deficiencies according to the number of residents affected (scope) and the seriousness of the deficiency (severity). Deficiencies are classified as isolated (one or a small number of residents), pattern (several residents), or widespread (pervasive in the facility). Deficiencies are also identified by four levels of severity – substantial compliance, no actual harm (with potential for more than minimal harm that is not immediate jeopardy), actual harm, and, for the most serious deficiencies, immediate jeopardy.[3]

The federal enforcement system

Under the federal enforcement system, CMS is responsible for enforcement of federal Requirements of Participation for nursing homes[4] that choose to be certified for participation in the Medicare program, more than 95% of facilities nationwide. States are responsible for enforcement of federal Requirements of Participation only in the small number of nursing homes that participate solely in the Medicaid program. In addition, under state licensing laws, states enforce state standards of care. These standards are applicable to all facilities in a state; they are the only standards applicable to the small handful of facilities that do not choose to participate in either Medicare or Medicaid.

The federal enforcement system gives most facilities an opportunity to correct their deficiencies before remedies are imposed. CMS's initial letter to a facility about its deficiencies advises the facility that, based on the state's recommendation, it may impose specified remedies if the facility fails to correct its deficiencies by a specific "date certain." If a revisit by the state survey agency finds that the facility has achieved substantial compliance by that date, the remedies are not imposed. The "opportunity to correct," authorized by the enforcement provisions of the State Operations Manual, but not by statute or regulations, means that the federal enforcement system

[3] The regulations define "immediate jeopardy" as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. §488.301.

[4] The Medicare program uses the term 'skilled nursing facility;' the Medicaid program, 'nursing facility.' This report uses the term 'nursing home' to describe facilities that appealed their deficiencies to the Departmental Appeals Board.

imposes remedies for failure to correct deficiencies, generally not for the citing of deficiencies. Under the federal system, many remedies that CMS proposes to impose are never actually imposed.

Even when deficiencies are cited, enforcement is generally discretionary. CMS may impose remedies but it is not required to do so. Under the 1987 Reform Law, imposition of the remedy "denial of payment for new admissions" is mandatory under two sets of circumstances. CMS must impose the remedy if a facility either fails to achieve substantial compliance within three months or if it is found to have provided substandard quality of care on three consecutive standard surveys. In all other circumstances, CMS has discretion to impose one or more remedies against facilities that are cited with deficiencies.

Although the Nursing Home Reform Law and regulations authorize states and CMS to impose a full range of remedies tailored to the scope and severity of a facility's deficiencies, CMS's State Operations Manual suggests that remedies should be imposed only for serious deficiencies. The undercoding of deficiencies, identified by numerous reports of the Government Accountability Office (GAO) since 1998, means that many deficiencies are identified as less serious than they actually are. Relatively few deficiencies are described as causing actual harm or immediate jeopardy to residents. As a result, relatively few deficiencies lead to the imposition of discretionary remedies.

Federal remedies include civil money penalties (CMPs), denial of payment for new admissions, directed in-service training, directed plan of correction, temporary management, and termination. All remedies other than civil money penalties may be imposed while a facility's administrative appeal is pending.

The dollar amount of per day CMPs is based on the severity of the deficiencies. Immediate jeopardy deficiencies carry per day CMPs of $3050-$10,000; non-immediate jeopardy deficiencies, per day CMPs of $50-$3000. When immediate jeopardy is removed, the CMP is reduced to the non-jeopardy range. The total amount of per day CMPs is a function of the amount of the per day CMP and the number of days that the CMP is imposed. CMS has not given states guidance on how to identify the appropriate duration of a facility's noncompliance. The federal regulations authorize a 35% reduction in a CMP if a facility foregoes an administrative appeal.

Per instance CMPs are $1000-$10,000. The full range of per instance CMPs is available for deficiencies, regardless of the scope or severity of the deficiencies, the number of days of noncompliance, or whether immediate jeopardy is cited.

Facility appeals of deficiencies

Facilities that have deficiencies cited against them may request informal dispute resolution (IDR), a proceeding in which they can challenge the factual basis of deficiencies. Some deficiencies are eliminated through the IDR process; other deficiencies have their scope or severity, or both, reduced. Although the federal regulations governing the enforcement system specify that IDR may not delay the formal administrative appeals process, in practice, facilities often use both IDR and formal appeals sequentially. They request IDR and, if deficiencies remain after IDR, they continue with their appeals.

Facilities that have remedies imposed against them may file an appeal with the DAB, an independent dispute resolution body at the Department of Health and Human Services. Facilities may appeal deficiencies only if remedies are imposed; they may not appeal deficiencies in the absence of remedies. Administrative Law Judges (ALJs) in the Civil Remedies Division of the DAB hold hearings or decide cases on the pleadings or motion.

Facilities sometimes choose not to appeal all the deficiencies cited against them. They may limit their appeals to the most significant deficiencies with the largest penalties; occasionally, they appeal only the duration of a CMP, not the underlying deficiency itself.

The overwhelming majority of facility appeals, perhaps 80% or more, are settled, often just before the administrative hearing. No information is publicly available about the number of cases that are settled or the actual terms of the settlements. Anecdotal information indicates that CMPs are sometimes reduced by more than 35% in settlements.

ALJs often address only some of the deficiencies cited by CMS. They discuss deficiencies that are sufficient to sustain the remedy(ies), not the additional deficiencies cited by CMS. Deficiencies that are not addressed are usually cited at a lower scope or severity, or both, than the deficiencies discussed in the decision, although, at times, an ALJ will address only one of a number of immediate jeopardy deficiencies.

Any party that is not satisfied with an ALJ decision – the facility or CMS, or both – may file an appeal with the Appellate Division of the DAB, which decides cases in three-judge panels. Appeals of Appellate Division are brought in federal court.

Most of the ALJ and DAB decisions address serious deficiencies for which CMPs were imposed.

State enforcement system

All states license nursing homes. As a condition of doing business in a state, a nursing home must have a state license. State licensure programs require surveys and may impose their own remedies for noncompliance with state standards. State licensure standards are often modeled on federal standards, but states may also enact state standards that go beyond federal standards in certain areas. Generally, when state surveyors conduct federal surveys, they also survey facilities for compliance with state-specific requirements.

After a survey, the state survey agency decides whether to cite deficiencies under federal law or comparable state law, or both. The states cite state deficiencies and facilities appeal state enforcement actions through the state appeals system. Some states have found that the federal enforcement system is too delayed, too cumbersome, and too limited, and have chosen to use their own state licensure system as the primary enforcement system in general or for certain deficiencies. Washington State, for example, imposes remedies for the existence of deficiencies, not for failure to correct deficiencies; California imposes fines of up to $100,000 when a facility caused the death of a resident.

As noted above, the state enforcement system is also used for the small handful of nursing homes that choose not to participate in the Medicare or Medicaid programs, or both; these facilities are not subject to the federal Requirements of Participation or the federal enforcement system.

This report's findings

This report describes the results of a review of all of the nursing home cases decided by the Civil Remedies and Appellate Divisions in calendar year 2007 – 66 at the Civil Remedies Division and 19 at the Appellate Division. The 85 cases most often involve serious failures in care – elopements, amputations of limbs, development of pressure sores, failure to give prescribed medication, and thirteen deaths.

Number of potential facility appeals is unknown

The universe of potential facility appeals is unknown and unknowable, with currently-available public information. Although the 15,000 nursing homes participating in the Medicare or Medicaid programs, or both, are subject to surveys to determine their compliance with federal law, only facilities that have remedies actually imposed against them have the right to an administrative appeal. Most facilities are cited with deficiencies; fewer than 10% of facilities are found to be deficiency-free. However, facilities that are cited with deficiencies have no right to appeal if remedies are dismissed before their effective date. The GAO has repeatedly reported that the overwhelming majority of facilities that are cited with deficiencies are given an opportunity to correct their deficiencies. The result is that most deficiencies cited by state survey agencies and CMS never lead to any enforcement actions. Immediate jeopardy deficiencies, the subject of a large portion of the cases at the DAB, are cited in a small number of facilities; just over 2% of facilities were cited with immediate jeopardy deficiencies in 2007.

The relatively small number of cases decided by the DAB in 2007 also reflects states' reliance on state licensure systems, rather than the federal enforcement system, when state remedies are faster and easier to implement. In addition, most cases appealed to the DAB are settled, leading to few adjudicated decisions.

CMS wins most cases at the DAB

As a general matter, CMS wins the cases that nursing homes file, with ALJs and the three-judge panels at the Appellate Division sustaining all of the deficiencies and the remedies imposed by CMS. On occasion, the ALJs reject some of the deficiencies or some of the resident examples; on rarer occasions, and particularly when they reject some deficiencies or some resident examples, they reduce the CMPs. In the interests of judicial economy, ALJs may not address all the deficiencies appealed by the facility; they may consider only the deficiencies that are sufficient to sustain the remedies imposed.

In 2007, CMS won, in whole or significant part, 66 of the 71 cases (93%) that were decided on their merits at the DAB. CMS won 48 of 53 decisions that were decided on their merits in the Civil Remedies Division, a 90% success rate, and all 18 decisions that were decided on their merits by the

Appellate Division, a 100% success rate. Fourteen cases (13 at the Civil Remedies Division, one at the Appellate Division) did not reach the merits.

ANALYSIS

The Civil Remedies Division

The Civil Remedies Division of the DAB issued 66 nursing home decisions from 25 states in 2007. Fifty-three decisions reached the merits; 13 did not.[5]

Forty-eight of the 53 decisions that reached the merits affirmed decisions of CMS to cite deficiencies and impose remedies; five decisions rejected the deficiencies and remedies either because CMS had not established a *prima facie* case or because the facility had rebutted CMS's *prima facie* case. Most of the 53 decisions that reached the merits involved serious deficiencies, frequently, the most serious "immediate jeopardy" deficiencies, and only one or a small number of residents. Most of the cases imposed CMPs.

Federal standards of care that are most often cited as deficiencies in ALJ cases

Failure to provide adequate supervision of residents, 42 C.F.R. §483.25(h)(2), is the most commonly-cited Requirement of Participation in the ALJ decisions. Seventeen of the 53 cases discussed this deficiency, reflecting a variety of failures in care:

- "Elopements" (a resident leaving the facility or expected location in the facility and the facility's not knowing that the resident has left or where the resident is, or both) (nine cases)
- Residents who left the facility and killed a man in a home invasion
- Falls
- Bedrail entrapment death
- Resident smoking; resident smoking, including smoking while using oxygen tank (three cases)

Elopement death
$64,050 civil money penalty

Briarwood Nursing Center, CR1551, involved a resident with a history of elopement who eloped through the window of her room; her body was found a week later. The Georgia nursing home had failed to implement its care plan for the resident, which required that she be monitored every two hours. A nurse falsified the midnight census report by counting the resident as present, even though she did not see the resident; the facility terminated the nurse for falsifying facility records. The ALJ sustained three immediate jeopardy deficiencies

[5] Thirteen of the 66 cases at the Civil Remedies Division did not reach the merits. ALJs dismissed seven cases when CMS rescinded all of the remedies prior to the hearing; three appeals were untimely filed; one case was a non-appealable issue (the effective date of recertification); one facility withdrew its appeal; and one case involved the facility's lack of authority to challenge the amount of a per instance civil money penalty.

related to the resident's elopement (supervision, §483.25(h)(2); neglect, §483.13(c)(1)(i); and professional standards of quality, §483.20(k)(3)(i)); he chose not to address other deficiencies cited by the survey agency. CMS imposed a $3050 per day CMP for the period September 11-October 1, 2002, totaling $64,050. The ALJ sustained the deficiencies and the CMP in full.

Quality of care, 42 C.F.R. §483.25, or a specific subset of quality of care, is the second most commonly-cited standard of care discussed in the ALJ decisions, cited in 14 of the 53 cases. Deficiencies under this regulatory citation include:

- Failure to assess or plan care for a resident who lost 50 pounds in a month, at a time when he was complaining of dizziness and weakness and was showing evidence of nausea, vomiting, and gastrointestinal distress
- Failure to provide appropriate tracheotomy care to residents after the respiratory company pulled its staff from the facility
- Development of avoidable pressure sores (e.g., failure to remove an immobilizer from a resident's leg for more than a month, resulting in the resident's development of avoidable pressure ulcers)
- Failure to provide incontinence care to residents
- Giving residents unnecessary drugs
- Failure to provide pain medication to a resident for three months
- Weight loss
- Dehydration

No pain medication for three months, one of five deficiencies
addressed by ALJ out of 17 cited by CMS
$7500 civil money penalty

Woods Edge Pointe, CR1699: The quality of care deficiency, §483.25, cited at a level of severity indicating no harm to residents, was based on the care of three residents. One resident at the Ohio nursing home, who had not been given any pain medication for three months, despite the physician's order that pain medication be administered on an "as needed" basis, cried out in pain when she was given care and stopped crying when care was completed, according to a certified nurse assistant. The facility failed to follow up on a second resident's need for dental care, identified in September 2002, at the time of the April 2003 survey. The facility failed to honor the third resident's care plan, which allowed her to self-test for blood sugar and self-administer her own insulin. For the quality of care deficiency and five other deficiencies addressed by the ALJ (out of 17 deficiencies cited by the state survey agency), CMS imposed a $250 per day civil money penalty, totaling $7500.

Failure to monitor resident's blood sugar levels,
leading to re-hospitalization with hypoglycemia four days after admission
$38,700 civil money penalty

The Laurels at Forest Glenn, CR1681: Quality of care, §483.25, and failure to notify the resident's physician of a significant change in the resident's condition, §483.10(b)(11), were cited as immediate jeopardy deficiencies when a facility failed to adequately monitor a resident's blood sugar, contrary to the hospital's direction to monitor the resident's blood sugar carefully. The result was the re-hospitalization of the resident with hypoglycemia four days after his admission. The ALJ sustained the per day CMPs imposed by CMS – five days at $3050 per day and 42 days at $50 per day, totaling $38,700.

Abuse and neglect, 42 C.F.R. §483.13(b) and (c), were cited in ten cases, including

- Abuse of residents by aide
- Failure to report and investigate reports of abuse
- Failure to investigate a resident's bruising over a four-month period
- Physical and mental abuse of residents by aides
- Choking death of a resident

Sexual assault of resident by aide and staff failure to report sexual assault;
additional deficiency cited for failure of supervision of another resident
$12,600 civil money penalty

Franklin Care Center, CR1694: A resident was sexually abused by a certified nurse assistant and suffered post-traumatic stress disorder as a result. Neither of the aides to whom she reported the assaults reported them. The next day, the same aide was assigned to take care of the resident. She told him to leave her room and reported the assaults again, this time, to a nurse. CMS cited two immediate jeopardy deficiencies for the assault, §§483.13(b), 483.13(c). Failure of supervision, §483.25(h)(2) was also cited for another resident's repeated falls, one of which resulted in the resident's hip fracture. The ALJ sustained the per day CMPs imposed by CMS – $3100 for three days, $100 for 33 days, totaling $12,600.

Choking death of resident, residents' dehydration during heat wave
$80,000 civil money penalty

Jennifer Matthew Nursing & Rehab Center, CR1717: A resident whose care plan required that he be fed by staff, fed himself a hotdog in the dining room, choked, and died. The facility failed to provide him with appropriate care and failed to report the incident. The state also cited the facility with failing to provide residents with necessary care and services during a heat wave, resulting in residents' suffering from dehydration. The ALJ noted the facility's "abysmal" history of noncompliance and reported that eight certified nurse assistants and licensed practical nurses at the facility had been convicted of neglect and falsifying medical records just prior to the incidents at issue in the appeal. She sustained three immediate jeopardy deficiencies – neglect, §483.13(c), quality of care, §483.25, and administration, §483.75 – and $10,000 per day CMPs for eight days, totaling $80,000.

Accident hazards, 42 C.F.R. §483.25(h)(1), were cited in five cases, including

- Wheelchairs not correctly fastened in facility van (two cases, one involving a resident death)
- Failing to remove a cigarette lighter and smoking materials from a resident after the wanderguard attached to him was found burned off

Professional standards of quality, 42 C.F.R. §483.20(k)(3), were cited in three cases, including

- Resident elopement
- Providing unnecessary drugs
- Failure to call a physician or begin CPR on a resident
- Allowing a resident to smoke while using oxygen

10 consecutive overdoses of morphine and other medication errors
$178,150 civil money penalty

Premier Living and Rehabilitation Center, CR1602, involved medication errors. Over the weekend of September 24-26, 2005, a hospice patient admitted to the North Carolina nursing home on September 21, 2005 received, from three nurses, 10 consecutive overdoses of morphine, each, ten times the amount of morphine prescribed by her physician. The ALJ found that nursing staff incorrectly measured the medication and failed to conduct an adequate investigation of the medication errors. She identified two additional medication errors by the facility's staff. Rejecting the facility's argument that the medication errors were attributable to "'human error' rather than some systemic breakdown," the ALJ sustained two immediate jeopardy deficiencies, failure to meet professional standards of quality, §483.20(k)(3)(i), and unnecessary drugs, §483.25(l)(1). CMS imposed a $3050 per day CMP for 58 days of immediate jeopardy and a $50 per day CMP for non-jeopardy noncompliance. The ALJ sustained the deficiencies and the CMPs, totaling $178,150. An appellate panel sustained the decision in its entirety. No. 2146 (Jan. 14, 2008).

The deficiencies are serious

More than half of the cases (32 of the 53 cases) reaching the merits at the ALJ level involved immediate jeopardy deficiencies. Facility failings cited as jeopardy included

- Nine cases involving residents who left the facilities without the facilities' awareness ("elopement"); two of these residents died
- Failure to assess and plan care for a resident who lost 50 pounds in a month, at a time when he was complaining of dizziness and weakness and was showing evidence of nausea, vomiting, and gastrointestinal distress
- Death by entrapment in a bedrail
- Failure to have any kind of working call system on one wing of a facility with 73 beds
- Failure of care planning, supervision, and rehabilitation of four residents who left the facility and, in a home invasion, murdered a person

 ©The Center for Medicare Advocacy

- Failure to secure residents' wheelchairs properly in facility's van, resulting in two accidents; one resident died
- Failure to identify hypoglycemia in a resident, requiring his return to the hospital in four days
- Failure to provide social services to a resident, despite his escalating behavioral issues, ending with the resident's suicide with a gun
- Resident whose care plan required him to be fed choked to death when he was allowed to feed himself a hotdog in the dining room, failure to provide appropriate care to residents during heat wave; abuse, quality of care, and administration deficiencies were cited at the immediate jeopardy level

Elopement death
$73,250 civil money penalty

Harlan Nursing Home, CR1644, involved a Kentucky nursing home's failure to provide adequate supervision for six residents, §483.25(h)(2), and failure in administration, §483.75. One resident, who had eloped from his previous facility and who was assessed as needing supervision at all times, eloped from the facility and was found outside, dead, by the maintenance supervisor. The facility's alarm system was routinely disengaged by the facility's staff to allow for vending machine deliveries and staff did not know how the alarm operated. The ALJ described the situation as "chaotic" and sustained the two deficiencies and the $8050 per day CMP for nine days and $100 per day CMP for eight days. The total CMP was $73,250.

Eight cases involved the death of a resident

Eight of the 53 cases involved the death of a resident.

- Entrapment on a bedrail and strangulation death, $4050 CMP
- Failure to consult with a resident's physician over the course of a week as the resident declined and ultimately died, $7000 CMP
- Failure to provide CPR to a resident, $10,000 CMP
- Elopement death, $64,050 CMP
- Two elopements, one death, $73,250 CMP
- Death by choking on a hotdog (and failure to provide hydration and care to residents during heat wave), $80,000 CMP
- Failure to provide social services to resident who committed suicide, $94,450 CMP

 ©The Center for Medicare Advocacy

- Failure to secure residents' wheelchairs properly in facility's van; two incidents; one resident died, $269,950 CMP[6]

One or a few residents are the subject of the deficiencies; fewer cases involve facility-wide deficiencies

Most of the cases involve the care of a single resident or a small number of residents; 23 of the 53 decisions discuss the care of a single resident and nine cases discuss the care of two to four residents.

Thirteen decisions discuss more than four residents:

- One decision discussed the non-functioning call system in the facility wing with 73 beds
- Two decisions discussed wheelchairs in facility vans
- Two decisions discussed Life Safety Code deficiencies
- One decision discussed housekeeping deficiencies
- One decision discussed the elopements of 10 residents
- Five decisions discussed multiple deficiencies affecting multiple residents
- One decision discussed the facility's failure to provide appropriate hydration and care to residents during a heat wave

The remaining decisions did not identify the number of residents affected by the deficiencies.

Civil money penalties are the most commonly-imposed remedies

Civil money penalties are the remedy that is most often discussed in the ALJ decisions. Forty-one decisions sustained CMPs, either alone or in combination with other remedies. In 26 of the 41 decisions, per day CMPs were imposed; in 14 decisions, per instance CMPs; and in one decision, both per day and per instance CMPs.

In only five cases with clearly identified remedies did CMS impose remedies other than CMPs; these remedies were denial of payment for new admissions, loss of authority to conduct a nurse aide training and competency evaluation program, and termination, or a combination of the three remedies.

The per day and per instance dollar amounts of civil money penalties are generally small; total per day CMPs are also generally small

The per day and per instance CMPs are generally imposed at the lower ends of the permissible ranges. When per day CMPs are imposed, the total amounts of the CMPs are also small.

Only seven decisions involved total per day CMPs over $100,000. Five cases were from North Carolina, one each, from Alabama and Kentucky:

[6] The ALJ's decision did not report that one of the residents died, but the Appellate Division issued in April 2008, which sustained the ALJ's decision in its entirety, reported that the resident injured in the second incident died.

- Physical abuse; failure report allegations of abuse; failure to implement abuse policies; $3050 for three days; then $1000 per day for 115 days; totaling $125,150

- Wheelchairs not secured in van and resident elopement; $3050 for 45 days, totaling $137,250 (then $100 per day; total unknown)

- Resident smoking and resident elopement; $3050 per day for 57 days, $50 per day for 31 days, totaling $175,400

- Unnecessary drugs for two resident; $3050 for 58 days, then $50 for 25 days, totaling $178,150

- Failure to have a functioning call system on one wing with 73 beds, for 71 days; $3050 per day CMP for 71 days, totaling $216,550 (then $100 per day CMP; total unknown)

- Failure to ensure a safe environment while transporting resident in facility van (one resident died); $4000 per day for 67 days, then $50 per day, totaling $269,950

- 10 resident elopements; $4050 per day for 240 days, totaling $974,500 (non-appealed deficiencies, $500 per day; total not specified)

Both cases involving the deaths of residents who eloped carried CMPs below $100,000; the CMPs for the two resident deaths were $64,050 and $73,250.

Per day CMPs

Twenty-six ALJ cases sustained per day CMPs.

Immediate jeopardy per day CMPs

Nineteen of the 26 cases imposing per day CMPs involved immediate jeopardy. Of these 19 immediate jeopardy cases, the lowest per day CMP for jeopardy ($3050) was imposed in 11 cases for deficiencies including

- Resident elopements
- Lack of any call system for a wing with 73 beds
- Repeated falls
- Unnecessary drugs
- Physical abuse of a resident by an aide
- Permitting a resident to smoke while using oxygen
- Failure to monitor a resident's blood sugar, leading to hypoglycemia
- Smoking and elopement
- Resident suicide

CMS generally imposed immediate jeopardy deficiencies at the lowest end of the CMP range and then reduced the CMP to the low end of the non-jeopardy range after jeopardy was removed.

The total amounts of these 19 immediate jeopardy deficiencies (depending on the number of days and levels of noncompliance) ranged from $4150 (repeated falls) to $974,500 (10 resident elopements)

Lack of a call system on one wing with 73 beds, July 27 - October 5
$216,500 civil money penalty

> *Care Center of Opelika*, CR1556, involved the lack of any type of call system on one wing of the Alabama nursing home with 73 beds, between July 27 and October 5, 2005. Although the facility's old call system had been malfunctioning for several months and broke down in July, the facility did not order a new system until September 6. The facility distributed hand bells to some residents on the wing, but did not give hand bells to all residents and did not have hand bells in the toilet and bathing areas. In late August, about a month after the call system broke, the facility assigned "bell monitors" to walk the halls listening for bells. Bell monitors were sometimes taken off the bell monitor assignment because of staff shortages. CMS found the bell system was not an adequate back-up system. The ALJ sustained an immediate jeopardy deficiency for failing to have a functioning call system, §483.70(f), and the $3050 per day CMP for 71 days, totaling $216,500. (CMS also cited two non-jeopardy deficiencies and imposed a $100 per day CMP.) On June 19, 2007, the ALJ's decision was affirmed on appeal by the Appellate Division. No. 2093.

In seven immediate jeopardy cases, the per day CMPs were imposed and sustained at higher than the minimum level. These immediate jeopardy per day CMPs ranged from $3100 per day (residents' smoking) to $10,000 per day (resident's choking death and failure to provide sufficient hydration and care to residents during heat wave). The total amounts of these seven immediate jeopardy deficiencies (depending on the number of days and the levels of noncompliance) ranged from $39,250 (uncontested deficiencies in quality of care, nursing services, physical environment, and administration) to $974,500 (failure to supervise, resulting in ten residents' elopements). The $974,500 CMP is an outlier, nearly four times the amount of the next highest per day CMP, $269,950 (accident hazards and administration, for failing to secure residents safely in the facility's van).

Non-jeopardy per day CMPs

CMS also set non-jeopardy per day CMPs at the low end of the range of $50 to $3000 per day. The seven non-jeopardy per day CMPS sustained at the ALJ level ranged from $200 per day for four deficiencies affecting 13 residents in pressure ulcers, accommodation of residents' needs, and incontinence care, to $500 per day in two cases. One case involved five deficiencies (care planning pressure ulcers, quality of care, supervision and assistance to prevent accidents); the other, pressure sores, unreported bruises, assessment, and dietary deficiencies.

Four deficiencies (pressure ulcers, incontinence care, call bells) involving 13 residents
$9800 civil money penalty

Beverly Healthcare – Ingram, CR1597, sustained four deficiencies at the Alabama nursing home involving 13 residents: (1) one resident developed avoidable pressure ulcers when the facility failed to remove the immobilizer on her leg between December 9, 2005 and January 17, 2006; (2) the facility failed to place call bells within the reach of four residents; and (3) the facility failed to provide proper incontinence care to four residents (two deficiencies). The ALJ sustained the deficiencies and the $200 per day CMP for the period January 20-March 9, 2006. The total was $9800.

Per instance CMPs

The fourteen per instance CMPs sustained at the ALJ level ranged from $1250 (dehydration) to two decisions imposing $10,000 per instance CMPs (one decision cited failure of supervision when two residents who left their facility engaged in a home invasion and murder; the other decision, two Life Safety Code deficiencies).

Five cases involving resident elopements resulted in per instance CMPs of $2000, $3000, $3100, $3300, and $7000.

Elopement; resident hospitalized with hypothermia and abrasions
$3000 civil money penalty

Mitchell Village Care Center, CR1589: After a resident tried to elope from the Iowa nursing home on December 31, 2003, the facility did not implement any additional interventions. The resident successfully eloped on January 2, 2004 and was found outside and taken to the hospital, where she was treated for hypothermia and abrasions. The ALJ sustained the immediate jeopardy deficiency for failure of supervision, §483.25(h)(2), and the $3000 per instance CMP.

Three of the 13 per instance CMPs involved the death of a resident. The per instance CMPs were $4050 ($3050 and $1000); $10,000 (two CMPs, each $5000), and $7000.

Resident death, following failure to call physician or initiate CPR
$10,000 civil money penalty

Apollo Health and Rehabilitation Center, CR1611: A resident admitted to the Florida nursing home on March 13, 2006 died less than a week later, on March 19, 2006, when the facility failed to call the resident's physician after her condition significantly changed. The facility also failed to initiate CPR when the nurse misread the resident's chart. The ALJ described as "amazing" and flying "in the face of reality" the facility's argument that the resident did not experience significant change, saying, "By any measure or standard the resident's disorientation and death throes were significant changes that demanded physician notification." The ALJ sustained two deficiencies, neglect, §483.13(c), and professional

standards of quality, §483.20(k)(3)(i), and chose not to address other allegations of noncompliance. He sustained two per instance CMPs, each $5000.

Resident death, failure to consult with physician
$7000 civil money penalty

Topeka Presbyterian Manor, CR1707: A resident who was found on the floor on January 3, 2005 and told staff of his Kansas nursing home that he had fallen out of wheelchair was sent to the hospital that day, returned to the facility four hours later, and declined over the course of the next several days, dying in the facility on January 10. The facility never contacted his physician and his physician never saw the resident before his death, despite the fact that the emergency room physician specifically ordered that the resident's physician be consulted. The ALJ sustained the deficiency for failure to consult with the physician following a significant change, §483.10(b)(11), and the $7000 per instance CMP.

The resident's strangulation death on her bedrail, which resulted in two per instance CMPs totaling $4050, was discussed at the beginning of this report.

Cases involved 25 states

The 66 ALJ decisions involved nursing homes in 25 states, with each state having one to seven cases:

Eight cases: North Carolina
Seven cases: Illinois
Six cases: Oklahoma
Five cases: Texas
Four cases: Iowa
Three cases: Alabama, Florida, Kansas, Kentucky, New Jersey, Ohio
Two cases: Connecticut, New York, Pennsylvania, Washington
One case: Arizona, Arkansas, California, Georgia, Idaho, Louisiana, Mississippi, Missouri, New Mexico, South Carolina

ALJs held hearings and decided cases on motion

ALJs decide cases by holding hearings or ruling on motions. Summary judgment decisions are issued when no material facts are in genuine dispute. Motions to dismiss reflect untimely appeals or appeals where CMS had previously dismissed all remedies.

The 66 ALJ cases were decided by:

- Hearings in 37 cases[7]
- Other methods in 30 cases:
  - Summary judgment: 6
  - Written record: 7

[7] One case had both a partial summary judgment decision and a second decision based on a hearing.

- Motions to dismiss: 13
- Stipulation: 1
- Motion for summary affirmance: 1
- Appeal withdrawn: 1
- Written exchanges: 1

Time elapsed between surveys and ALJ decisions

The 2007 ALJ decisions reflected surveys that occurred between 2001 and 2007:

2001: 1 survey
2002: 2 surveys
2003: 9 surveys
2004: 8 surveys
2005: 14 surveys
2006: 23 surveys
2007: 5 surveys

No survey date was identified in four decisions.

Cases that were decided by motion or on the written record were decided more quickly than those involving a hearing before the ALJ; only three cases decided by motion were based on surveys in 2003 and 2004. Cases decided by hearing included one survey in 2001, two surveys in 2002, eight surveys in 2003, six surveys in 2004, ten surveys in 2005, and eight surveys in 2006.

The time between hearing and ALJ decision ranged from two to 40 months.

Cases where the ALJ rejected the deficiencies

In five of 53 cases decided on the merits, two of which involved the death of a resident, the ALJ rejected the deficiencies cited by CMS. The ALJ found either that CMS failed to establish a *prima facie* case of noncompliance or that the facility rebutted CMS's *prima facie* case by a preponderance of the evidence. As a consequence, the ALJs also dismissed the remedies that CMS imposed.

IHS of Kansas City, CR1585, rejected the immediate jeopardy quality of care deficiency, §483.25, cited against the Missouri for failure to identify the decline of a resident, who died. While describing the resident's care as "not perfect," the ALJ found that the facility's staff acted reasonably, "given the Resident's complex medical situation." The ALJ found the facility in substantial compliance and rejected the $10,000 per instance CMP.

Bloomfield Health Care Center, CR1610, rejected the deficiency for failure to provide one resident at the Connecticut nursing home with proper hydration, in violation of §483.25(j). The ALJ acknowledged that the facility's assessment and care plans for the resident were not models and were not "perfectly documented or executed." Nevertheless, he rejected the deficiency, relying on two physicians, who testified that the resident's hospitalization was precipitated by an episodic manifestation of mesenteric ischemia, which mimics dehydration.

The ALJ found the facility in substantial compliance with Requirements and rejected the per instance CMP of $1000.

Sheridan Health Care Center, CR1641, rejected three deficiencies, including a quality of care deficiency, §483.25, cited at the Illinois nursing home at the immediate jeopardy level, involving the care of a resident who fasted to death in the exercise of his religious beliefs. The ALJ found that the facility's staff was attentive and accommodating to the resident during his 5½-year stay, even though some of the entries in the resident's record were late and not perfectly documented. He described the case as "extremely unusual and difficult," found that the facility had rebutted CMS's *prima facie* case, and rejected the $3050 and $200 per day CMPs that totaled $27,600.

Haven Health Care of Windham, CR1656, rejected the deficiency cited against the Connecticut nursing home for failure to notify a physician of a significant change in a resident's condition, in violation of §483.10(b)(11). The ALJ found that CMS did not present any expert medical testimony to establish that any change in the resident's condition was either life-threatening or a clinical complication. Finding that CMS had not established a *prima facie* case of noncompliance, he rejected the deficiency and the $2000 per instance CMP.

Crestview Acres, CR1718, rejected two deficiencies, a jeopardy-level failure of supervision, §483.25(h)(2), and abuse, §483.13(b), cited against an Iowa nursing home for the sexual assault of a female resident by a male resident. The ALJ found that the facility had no reason to "expect, or fear, or anticipate" that the resident would commit a sexual assault when his prior relationships with three female residents were consensual and non-sexual. The facility documented that it counseled the male resident about these prior relationships; used anti-psychotic medications and female hormone replacement medication to decrease the resident's libido; made hourly checks of the resident; and promptly discharged him to a hospital and then permanently discharged him after the sexual assault. The surveyor originally assigned to investigate the complaint testified, on behalf of the facility, that the survey agency appeared to want her to substantiate the complaint and that she was removed from the case after she told her superiors in the state survey agency that she had found the facility in substantial compliance. The ALJ found that the facility rebutted CMS's *prima face* case and rejected the $10,000 per instance CMP.

The Appellate Division

The Appellate Division of the Departmental Appeals Board issued 18 nursing home decisions from 11 states in 2007. All 17 decisions that reached the merits affirmed decisions of CMS, in whole or in part, to cite deficiencies and impose remedies; one case affirmed the ALJ's dismissal of an untimely appeal. Like the ALJ decisions at the Civil Remedies Division, most of the cases at the Appellate Division involved serious deficiencies, frequently, the most serious "immediate jeopardy" deficiencies, involving one or a small number of residents. Most of the cases imposed CMPs.

Panel decisions frequently began with a discussion of legal issues – whether the ALJ applied the correct legal standard and burden of proof, whether the ALJ properly conducted the hearing and

gave appropriate weight to the witnesses' testimony. The Appellate Division decisions generally included fewer facts about the cases and the deficiencies.

Federal standards of care that are most often cited as deficiencies in Appellate Division cases

The same deficiencies were addressed in the Appellate Division decisions as in the Civil Remedies Division decisions.

Failure to provide adequate supervision of residents, 42 C.F.R. §483.25(h)(2), was cited in six cases; four decisions involved resident elopements; one decision, two residents' smoking (one resident eloped; one burned himself); and one decision, the facility's failure to take any action when the husband of a resident did not return his wife to the facility after dialysis.

Smoking with oxygen, elopement
$163,700 civil money penalty

Century Care of Crystal City, No. 2076: The facility had a smoking policy for residents, but was lax and inconsistent in its implementation of the policy. One resident, who had a history of "'confusion, delirium, and unsafe behaviors, including unsafe smoking behaviors,'" burned himself while smoking when using oxygen; he was treated at the emergency room. A second resident who smoked, whose history included wandering and elopement, eloped from the facility, unobserved by staff; a doctor's office called the facility to report her presence. Staff did not document or report the second resident's elopement and the facility learned of the elopement two months later from surveyors who were investigating a complaint about the first resident's smoking incident. CMS cited the facility with failure of supervision, §483.25(h)(2), and administration, §483.75, both at the immediate jeopardy level. The ALJ sustained both immediate jeopardy deficiencies (the facility did not appeal the non-jeopardy deficiencies) and the CMPs, $3050 per day for 52 days and $150 per day for 34 days, totaling $163,700. An appellate panel affirmed the decision.

Abuse and neglect, 42 C.F.R. §483.13(b) and (c), were cited in four cases for

- Failing to provide services to a resident
- A massive fire ant attack on a resident
- Failing to follow facility policy on abuse (the facility appealed only the duration of the deficiency, not the deficiency itself)
- Failing to investigate an injury of unknown origin (two cases)

Failure to investigate injury of unknown origin
$16,800 civil money penalty

Rosewood Care Center of Inverness, CR2120: On November 16, 2005, a resident told staff at her Illinois nursing home that she had injured her right shoulder when she bumped against the bathroom door frame. An x-ray was negative. On November 21, she told staff that she had pain in her right side and an irregular heartbeat. The hospital where she was admitted

 ©The Center for Medicare Advocacy

that day advised the facility that the resident had congestive heart failure and a fractured right clavicle. The facility failed to investigate the cause of the resident's fractured clavicle until the surveyor told the facility on December 27 that the resident said she had been pulled by the arms by a member of the facility's staff. CMS cited the facility with failure to investigate an injury of unknown origin, §483.13(c)(3), and failure to ensure adequate supervision, §483.25(h)(2), and with five additional deficiencies. CMS imposed a $300 per day CMP for the period January 6-March 2, 2006, totaling $16,800. The ALJ found that the negative x-ray for injury to the resident's shoulder on November 16 did not excuse the facility's failure to investigate the resident's broken clavicle, which was identified by the hospital on November 21. He granted summary judgment on the investigation deficiency and sustained the CMP. An appellate panel affirmed the decision in its entirety.

Professional standards of quality, 42 C.F.R. §483.20(k)(3), was cited in three cases:

- A nurse's administering the wrong medications to a resident
- Failure to ensure that 22 of 174 nursing staff members were timely recertified in CPR, after the facility failed to provide CPR to a resident, who died
- Failure to investigate when a husband failed to return his wife to the facility following dialysis

Medication errors by contract nurse
$3100 civil money penalty

Daughters of Miriam Center, CR2067: A contract nurse at the New Jersey nursing home reported to her supervisor that she had injected a resident with an antibiotic, contrary to the physician's order that the antibiotic be given by mouth. After the nurse reported the incident, the facility discovered that the nurse had made a second medication error on the same shift. She gave two medications that were prescribed for a resident to that resident's roommate, who had also refused the insulin injection ordered for her roommate. CMS cited the facility with violating professional standards of nursing practice, §483.20(k)(3), at the immediate jeopardy level, and imposed a per instance CMP of $3100. The ALJ found that CMS had not established a *prima facie* case of immediate jeopardy and reduced the CMP to $1000. Reversing the ALJ's decision, an appellate panel reinstated the $3100 per instance CMP.

Failure to provide CPR to resident who died
$53,200 civil money penalty

John J. Kane Regional Center – Glen Hazel, No. 2068: A resident in cardiac distress, who was not transferred to the hospital or given emergency treatment, including CPR, in violation of §483.25, died at the facility. Surveyors determined that the facility did not ensure that 22 of 174 nursing staff were timely recertified in CPR, in violation of §483.20(k)(3)(ii). The ALJ reduced the per day CMP from $1500 to $700 for 76 days, totaling $53,200. The panel affirmed the ALJ's decision.

 ©The Center for Medicare Advocacy

Quality of care, 42 C.F.R. §483.25

- Failure to provide appropriate catheter care, pressure ulcers
- Failure to provide CPR

Accident hazards, 42 C.F.R. §483.25(h)(1)

- Restraints, seat belts in van
- Handroll, finger amputation

Amputation of finger
$5000 civil money penalty

Lutheran Home at Trinity Oaks, No. 2111: Staff at the North Carolina nursing home gave a resident a handmade handroll, whose elastic strap was old and loose. Staff repeatedly saw the resident with the handroll wrapped around her fingers. One morning, the handroll was found wrapped around one of the resident's fingers, which had become necrotic and had to be amputated. CMS cited the facility with failing to maintain the environment free of accident hazards, §483.25(h)(1), and imposed a $5000 per day CMP for one day. CMS also imposed a $250 per day CMP for additional deficiencies, which were not identified in the decision. The ALJ rejected the facility's argument that the accident was unprecedented, calling the incident a reasonably foreseeable hazard. She sustained the deficiency and remedy. The panel affirmed the ALJ's decision.

Pest control, 42 C.F.R. 483.70(h)(4), involved fire ant infestations in two facilities.

Fire ant attack on resident
$79,300 civil money penalty

Lake Mary Health Care, No. 2081: On August 10, 2003, fire ants were seen in the room of a bedfast, totally dependent resident. On August 20, at 4:30 a.m., she was found in her room "with a large number of ants on her face and upper body and with numerous ant stings." The facility was cited with two immediate jeopardy deficiencies – neglect, in violation of §483.13(c)(1)(i), and environment, in violation of §483.70. The ALJ sustained the deficiencies, finding that the facility did not follow its own pest control policy and did respond adequately to repeated sightings of ants in 2003. He sustained per day CMPs – $3050 for 26 days, totaling $79,300 and $100 thereafter (total number of days, not identified). An appellate panel affirmed the ALJ's decision in full.

The deficiencies are serious

Nearly three-quarters of the cases (13 of 18) reaching the merits involved immediate jeopardy deficiencies. Facility failings cited as immediate jeopardy included

- A contract nurse's administering the wrong medication to two residents
- Failure to provide CPR to a resident, who died

- Resident elopements (five decisions), one ending in the resident's death
- Pest control deficiencies (two decisions), including a massive fire ant attack on one resident
- Failure to provide appropriate supervision to two smokers; one eloped; one burned himself
- Failure to develop a care plan and provide services to a resident, who died
- Failure of supervision and administration, by failing to investigate when a resident's husband did not return her to the facility following dialysis
- Failure to have a functioning call system
- Restraints used as seat belts in facility van
- Failure to provide a safe environment; staff gave the resident a handroll with loose elastic that she repeatedly wrapped her finger, leading to necrosis and amputation of her finger
- Failure to follow facility policy on abuse, following the rape of a resident by an aide
- Failure to investigate a resident's injury of unknown origin after the hospital reported that the resident had a broken clavicle

Failure to plan care for neurogenic bowel condition of resident
admitted for respite care; resident died
$120,000 civil money penalty

Britthaven of Havelock, No. 2078: A 45-year-old man with quadraplegia, who was admitted to the North Carolina facility on June 25, 2002 for short-term respite care while his mother had surgery, died on September 2 when the facility did not develop a care plan for his neurogenic bowel condition, did not follow-up on the attending physician's note and August 9 x-ray showing a bowel obstruction, and did not inform the physician when the resident refused the ordered treatment. The facility with cited with neglect, §483.13(c), for failing to develop a care plan or provide the resident with services to avoid physical harm. The State had recommended a $10,000 per instance CMP; CMS changed the remedy to two $5000 per day CMPs for the period August 10-September 5. The ALJ sustained the deficiency, but held that the facility's noncompliance ended on September 2, the date of resident's death. He sustained the two $5000 per day CMPs for 24 days, totaling $120,000. The panel affirmed the ALJ's decision in full.

Three decisions involved the death of a resident

Three of the 17 cases reaching the merits involved the death of a resident.

- Failure to provide CPR to a resident who died, $53,200 CMP
- Elopement, $64,150 CMP
- Failure to develop a care plan or provide services, $120,000 CMP

One or a few residents are the subject of the deficiencies; fewer cases involve facility-wide deficiencies

Ten cases involved a single resident; three cases involved two residents.

Five cases involved more than four residents:

- One decision affirmed three deficiencies – catheter care, three residents' pressure ulcers, and quality of food
- One decision reversed the ALJ's decision overturning the determination of five deficiencies; the panel sustained two of the five deficiencies (restorative dining for one resident, care planning for three residents)
- Pest control deficiency
- Failure to have functional call system
- Staff failure to follow facility's policy on abuse

Civil money penalties are the most commonly-imposed remedies

All but one case involved CMPs; one case affirmed a termination.

The per day and per instance dollar amounts of civil money penalties are generally small; total per day CMPs are also generally small

Per day CMPs

Fifteen decisions involved per day CMPs; 11 of the 15 decisions involved immediate jeopardy deficiencies and CMPs.

Four decisions involved total per day CMPs over $100,000. Three of the decisions involved North Carolina nursing homes, one, an Alabama facility.

- Failure to develop care plan for resident, admitted for short-term respite care, who died; $5000 per day for 24 days, totaling $120,000

- Failure of supervision for two residents who smoked (one resident burned himself while smoking and using oxygen; the other resident eloped); $3050 per day for 52 days, followed by a $150 per day CMP for 34 days, totaling $163,700

- Failure of supervision, with elopement of resident who had eloped many times before by deactivating the same switch; $3500 per day for 60 days, totaling $210,000 ($100 per day CMP; total number of days unknown)

- Failure to have a functional call light system for a wing with 73 beds for 71 days; $3050 per day, totaling $216,550 ($100 per day CMP; total number of days unknown)

Immediate jeopardy per day CMPs

Eleven decisions imposed per day CMPs for immediate jeopardy deficiencies. Five of the 11 decisions imposed the minimum immediate jeopardy per day CMP, $3050:

- Accident hazards (restraints used as seat belts in facility van), neglect, resident elopement, $3050 per day for one day for three immediate jeopardy deficiencies, then $100, total not specified

- Elopement resulting in resident death, three immediate jeopardy deficiencies, $3050 per day for 21 days, total $64,150 (facility appealed only duration of CMP, which panel affirmed in full)

- Massive fire ant attack on one resident, two immediate jeopardy deficiencies for abuse and pest control; $3050 per day for 26 days (total $79,300); then $100 per day

- Failure of supervision for two residents who smoked (one eloped; one burned himself), $3050 per day for 52 days; $150 per day for 34 days; total $163,700)

- Failure to have functional call light system for wing with 73 beds, $3050 per day for 71 days, total $216,550

Six decisions imposed immediate jeopardy per day CMPs above the minimum:

- Resident was given loose and ill-fitting handroll by staff, which she repeatedly wrapped around her finger, ultimately leading to amputation of her finger, $5000 per day for one day, $250 per day for other deficiencies, total CMP not specified

- Failure to provide supervision to or find resident whose husband did not return her to facility following dialysis, $4000 per day for two days, total $8000, then $250 per day

- Staff failure to follow facility policy after aide raped a resident, $4150 for five days, total $20,750, then $50 per day for unknown number of days

- Pest control deficiency, $8500 per day for 6 days, total $51,000

- Failure to develop care plan for resident, admitted for short-term respite care, who died, $5000 per day for 24 days, total $120,000

- Elopement of resident who had eloped many times before by deactivating the same switch, $3500 per day for 60 days, total $210,000, then $50 per day, total unknown

Non-jeopardy per day CMPs

Three decisions addressed non-jeopardy per day CMPs:

- Failure to investigate injury of unknown origin after hospital reported that resident had broken clavicle, $300 per day for 56 days, total $16,800

- Two quality of care deficiencies (catheter, pressure ulcers for three residents); food deficiency, $400 per day for 48 days, total $19,200

- Failure to provide CPR to resident, who died, $700 per day for 49 days, total $53,200

Per instance CMPs

Two decisions involved a per instance CMP. The panel reinstated the $3100 per instance CMP imposed by CMS, which the ALJ had reduced to $1000, when a contract nurse gave wrong medications to two residents and the first error was reported by the nurse, not identified by the facility. A per instance CMP of $3050 was imposed for an elopement.

Cases involved 11 states

The 18 Appellate Division decisions involved nursing homes in 11 states, with each state having one to six cases:

Six cases: North Carolina
Two cases: Florida, Illinois
One case: Alabama, Georgia, Michigan, New Jersey, Ohio, Pennsylvania, Virginia, Wisconsin

ALJs held hearings and decided cases on motion

- Hearings were held in 14 cases
- Other methods in four cases:
  - Written record: 1
  - Summary judgment: 2
  - Motion to dismiss: 1

Time elapsed between surveys and ALJ decisions

The 2007 Appellate Division decisions reflected surveys that occurred between 2002 and 2006.

2002: 3 surveys
2003: 3 surveys
2004: 6 surveys
2005: 4 surveys
2006: 1 survey

One decision did not identify the date of the survey.

 ©The Center for Medicare Advocacy

DISCUSSION AND RECOMMENDATIONS

A review of the 85 decisions issued by the DAB in 2007 demonstrates that deficiencies cited in nursing homes across the country are serious. State survey agencies and CMS identify extreme failures of care that, in many instances, led to unnecessary pain, injury, trauma, and death.

Despite the seriousness of the harm that residents suffer, the enforcement system imposed remedies that were modest at best. States and CMS generally imposed per day CMPs at the lowest end of the permissible range and total CMPs were almost always small, if not trivial, in comparison to the harm endured.

When nursing homes appealed these serious deficiencies and modest penalties, they lost their appeals.

What do these findings mean?

First, the regulatory system, unchanged for more than a decade, needs to be updated. A stronger and faster enforcement response is needed to the serious noncompliance that is cited. CMS must impose remedies for the existence of deficiencies, not just for facilities' failure to correct deficiencies. Fines must be increased to reflect more accurately the seriousness of the harm that is identified. New guidance to states should explain how to identify the appropriate duration of noncompliance. New federal remedies are needed to respond more quickly and appropriately to failures in care.

Second, more public information is needed about the survey and enforcement systems and about the appeals process.

At present, there is little information available to the public about enforcement actions taken against facilities that are cited with deficiencies. CMS does not publicize its enforcement activity, either at the time of imposing remedies against a specific nursing home or in a monthly, quarterly, or annual report. CMS's nursing home information website, *Nursing Home Compare*, identifies the number of deficiencies cited against facilities over a three-year period, but it identifies deficiencies solely by the regulatory provision that is cited. The website does not describe what specific problems surveyors actually found and why surveyors cited the particular deficiency. There is no link to the federal survey form, CMS 2567. In addition, *Nursing Home Compare* does not include any information about enforcement actions.

In November 2007, CMS began to publicize its Special Focus Facility (SFF) Initiative. This Initiative requires state survey agencies to conduct an additional survey each year in facilities whose three-year survey history identifies them as providing exceptionally poor care. In April 2008, CMS began to identify SFFs on *Nursing Home Compare*. CMS's limited disclosure of poor care in a small number of facilities (134 facilities in April 2008) provides some new information, but may also have an unintended consequence of suggesting to the public that facilities without the SFF designation provide acceptable care.

CMS also does not publicize any information about facilities' administrative appeals – their number, substance, or outcome – and it should.

CONCLUSION

The federal deficiencies cited by state survey agencies and the remedies imposed by CMS reflect serious failures in care for residents – amputations, dehydration, overmedication, undermedication, elopements, and deaths. These serious failures in care are not matched by significant penalties. The enforcement consequences of poor care are generally modest. Despite the limited enforcement response to poor care, nursing homes appeal the remedies imposed against them. Almost always, these appeals do not succeed.

 ©The Center for Medicare Advocacy

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NURSING HOME ENFORCEMENT: COLLECTION OF CIVIL MONEY PENALTIES

Daniel R. Levinson
Inspector General

July 2005
OEI-06-03-00420

EXECUTIVE SUMMARY

OBJECTIVE

To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) collected civil money penalties (CMPs) and took required collection actions for nursing home enforcement cases initiated in calendar year (CY) 2002.

BACKGROUND

CMPs are fines that CMS can impose on Medicare- and Medicaid-certified nursing facilities that are found to be noncompliant with Federal safety and quality of care standards. CMS is charged with ensuring that facilities pay their fines and is required by Federal law, regulations, and policies to take specified collection actions. Delays in collections, or lack of collections, have the potential to undermine the CMPs' intended effect of ensuring that facilities promptly return to compliance.

Required collection actions include providing facilities with complete notification that the CMP is due, assessing interest on unpaid balances, referring past-due CMPs to fiscal intermediaries and State Medicaid agencies to be offset from funds owed to facilities, and transferring debt over 180 days past due to the Department of the Treasury.

We examined case information obtained from CMS to determine whether each of the CMPs initiated in CY 2002 were collected in full, partially collected, or remained uncollected as of March 2004. We also assessed timeliness of collections. Through analysis of documentary evidence we determined the extent to which CMS took all required actions to collect the 228 CMPs that became past due by more than 30 days. Information obtained from interviews with CMS staff in the central office and each of the 10 regional offices provided additional information about collection procedures.

FINDINGS

As of March 2004, CMS did not fully collect 4 percent of the CMPs imposed in CY 2002 and collected another 8 percent well after the due dates. We found that 12 percent (228 out of 1,938) of collectable CMPs initiated in CY 2002 became past due by more than 30 days. CMS had not fully collected 79 CMPs (4 percent of the total) by March 2004, the end of our study period. Further, the collection that did occur (149 collected cases) was often very late, with an average collection time of 115 days past the due date.

Forty-four CMPs had no collections during this time period. Of these CMPs, 31 were for facilities that were found to be out of compliance in an inspection following the one that resulted in the imposition of the CMP.

CMS did not take all required actions to collect 94 percent of past-due CMPs, but took some actions beyond those required that improved collection results. For 40 percent of past-due CMPs, CMS failed to provide complete notification with all required information, including when the CMPs were due. CMS did not assess interest on 72 percent of the past-due CMPs as required and did not refer 71 percent of past-due CMPs to fiscal intermediaries and State Medicaid agencies to initiate collection through offsetting of funds owed to the facilities. Finally, CMS did not transfer any of the 95 CMPs that became over 180 days past due to the Department of the Treasury as required. However, we found that CMS sometimes took additional collection actions that are not required, such as sending past-due letters or making telephone calls to facility administrators. About half of the facilities contacted submitted payments to CMS within a month following such contact.

Responsibilities for CMP collections are neither clearly defined nor commonly agreed upon. CMS central office staff view CMP collections as primarily a regional office responsibility. While some regional office staffs agree that their offices are primarily responsible for collecting CMPs, others expressed the belief that collection efforts are the responsibility of the central office.

Databases used for tracking CMP collections contained inaccurate and incomplete information, causing collection errors and frustrating staff. In some cases, inaccurate information in CMS databases used for tracking CMP payments made them erroneously appear to be past due. CMS regional office staff reported that such data inaccuracies create a disincentive for them to attempt to collect past-due CMPs because they do not want to request payment for a CMP that is not collectable or has been paid. In part, CMP data errors are attributable to CMS's using three different databases to process CMPs. These databases do not interface with each other and lack an effective means for staff to identify data errors. Lack of feedback to CMS about offsets by State Medicaid agencies also results in incomplete data.

RECOMMENDATIONS

To ensure that all CMPs are fully collected as timely as possible, we recommend that CMS:

Provide oversight to ensure that all required actions for collecting CMPs are taken. Specifically, CMS should ensure that collection staff provide facilities with complete notice when CMPs are due, assess interest on all past-due CMPs, routinely refer past-due CMPs to fiscal intermediaries and State Medicaid agencies to initiate collection through offsets from funds owed to the facilities, and routinely transfer CMPs over 180 days past due to the Department of the Treasury.

Educate staff with written guidelines to clarify responsibilities for, and priority of, CMP collections. CMS should issue a new set of guidelines with more clearly delineated responsibilities and increased emphasis on the importance of collections to provide staff with needed clarity about expectations for various actions.

Ensure the accuracy of information contained in databases used for tracking CMP collections while making them easier to use. A review of CMP cases from CY 2002 revealed multiple instances of inaccurate data, which reportedly create a disincentive for staff to engage in required collection actions because they do not want to attempt to collect an incorrect amount or to collect CMPs that are not due or have already been paid.

AGENCY COMMENTS

CMS concurred with our recommendations. The agency further commented that it has recently or will soon implement all of the OIG recommendations.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NURSING HOME ENFORCEMENT: THE USE OF CIVIL MONEY PENALTIES

Inspector General

April 2005
OEI-06-02-00720

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. The OEI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

EXECUTIVE SUMMARY

OBJECTIVE

To describe reduction, assessment, and collection patterns for civil money penalties (CMP) imposed by the Centers for Medicare & Medicaid Services (CMS) in calendar years 2000 and 2001.

BACKGROUND

The CMPs are one of eight discretionary remedies CMS may use to address deficiencies in quality of care or safety standards. The CMPs may be assessed per day of noncompliance or per instance of noncompliance. Additionally, CMPs have required dollar ranges that correspond to the seriousness of harm to the patient(s).

We analyzed 100 percent of data from CMS's regionally-based Long-Term Care Enforcement Tracking System for enforcement cases beginning in 2000 and 2001 in which a CMP was imposed. These data were supplemented with information from the CMP Tracking System, housed in CMS's central office. We also interviewed staff at CMS's regional offices and the Department of Health and Human Services, Departmental Appeals Board.

FINDINGS

While $81.7 million in CMPs was imposed during 2000 and 2001, $34.6 million (42 percent) was paid by December 2002. The difference is primarily attributable to reductions authorized by regulation and delays in making and collecting payments. Although CMPs are used quite frequently (51 percent of CMS enforcement cases), the CMP amounts originally imposed are often substantially decreased before payment is due. Under current regulations, systematic reductions, appeals, settlements, and bankruptcies are the main factors contributing to this decrease.

Seventy percent of CMP cases (2,973) received a reduction from the full amount imposed prior to payment request. Every nursing home is entitled to a 35 percent reduction for waiving its right to appeal. Appeal waivers and appeal settlements account for $22.7 million in reductions.

Fourteen percent of cases with CMPs due remained uncollected as of December 2002; bankruptcies and inconsistencies in the collections process were the primary causes. At the end of our tracking period, 550 cases, totaling $11.7 million in CMPs due, were still outstanding.

The most frequent reasons for nonpayment were bankruptcies and cases for which there was no documentation that CMS attempted to collect.

Eight percent of all CMP cases were not yet due by December 2002. By the end of our data tracking period, 339 cases had been delayed for more than a year, almost exclusively the result of processing appeals and/or bankruptcies.

CMS does not utilize the full dollar range allowed for CMPs; impositions tend toward the lower ends of the ranges. The median per day imposition amount for the most severe (immediate jeopardy) cases was about $4,000, at the 15th percentile of the allowable range ($3,050 to $10,000). The median per day imposition amount for less severe cases involving a CMP was $250, at the 7th percentile of the allowable range ($50 to $3,000).

Cases not appealed took over 6 months to collect; appealed cases took substantially longer. The Social Security Act specifies that remedies should be designed ". . . to minimize the time between the identification of violations and final imposition of the remedies." Required procedures slow this timeframe for all CMP cases, and appealed cases took twice as long to collect as cases not appealed. In those cases, CMS's collection efforts cease until an administrative decision is reached; therefore, total collection time in appealed cases includes the time attributed to the administrative appeals process.

RECOMMENDATIONS

This inspection highlights several conditions within the current enforcement system that could be improved. We recommend that CMS:

- Provide written guidance to CMS staff and States regarding appropriate dollar ranges for individual ratings of scope and severity.
- Provide written guidance to CMS staff to clarify responsibilities with respect to past due CMPs and to conduct an internal process review that would enable CMS and States to streamline CMP processing.

Agency Comments

CMS concurred with our recommendations. The agency further commented it has already begun work to promote consistent imposition of CMPs and to develop appropriate policy guidance regarding

responsibility for collection of past-due CMPs and streamlined CMP processing.

CMS noted that we included required reductions for appeal waivers, appeals, and settlements in a discussion of CMP amounts imposed and paid. CMS suggested that an Office of Inspector General (OIG) analysis of the collection process should more properly begin with the amount remaining after accounting for these required reductions and that doing otherwise may imply OIG criticism of CMS performance. We recognize that reductions for appeal waivers, appeals, and settlements are required by Federal regulations, and we appreciate CMS's concern in this matter. For this reason, we have made certain to clearly denote throughout the report which reductions are obligatory.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PROVIDER ENROLLMENT, CHAIN AND OWNERSHIP SYSTEM: EARLY IMPLEMENTATION CHALLENGES

Daniel R. Levinson
Inspector General

April 2007
OEI-07-05-00100

EXECUTIVE SUMMARY

OBJECTIVE

To assess the early implementation of the Provider Enrollment, Chain and Ownership System (PECOS) related to the timely processing of Medicare provider enrollment applications and system access.

BACKGROUND

The PECOS is the repository of enrollment records for Medicare providers, such as physicians, hospitals, and laboratories. It is the primary source for provider enrollment information and serves as the frontline defense to keep fraudulent providers from participating in Medicare. The PECOS was expected to greatly reduce the amount of time needed to process provider enrollment applications. When the PECOS began operating in 2002, implementation problems caused delays in processing enrollment applications.

The PECOS began initial operations with Part A contractors in July 2002; Part B contractors followed in November 2003. It contains providers' full names; unique identifiers, such as Social Security numbers or tax identification (ID) numbers; and relationships between providers (e.g., group practices and ownership). The system is not fully populated with all Medicare providers, nor is it used to enroll all provider types (e.g., durable medical equipment suppliers). Future plans for the PECOS include housing each provider's National Provider Identifier and inclusion of enrollment information for durable medical equipment suppliers and Medicaid providers.

The Office of Inspector General (OIG) collected records from contractors of all provider enrollment applications exceeding the Centers for Medicare & Medicaid Services (CMS) timeframes for July 2005. OIG aggregated this data, selected stratified random samples of applications, and contacted the contractor that owned each application to determine the reason it was delayed. Between November 2005 and January 2006, OIG conducted structured interviews with all contractors regarding their experiences with PECOS, factors that commonly delay processing of applications, PECOS training and guidance received, their understanding of application-processing procedures, and their oversight by CMS. OIG also conducted structured interviews with provider enrollment and PECOS access staff in each CMS regional office and in CMS's central office.

FINDINGS

Because of misinterpretation of CMS guidance, the majority of Part A applications contractors reported as exceeding timeframes as of July 31, 2005, had not actually exceeded timeframes. Sixty-six percent of the Part A applications reported as exceeding the 99-percent processing timeframe had not actually exceeded it. The misclassification was due to the fact that contractors retained applications awaiting tie-in notices in pending inventory or failed to update the record status in the PECOS correctly. Eighteen percent of Part A applications reported as exceeding timeframes were delayed due to a backlog of applications waiting to be processed by one contractor. The remaining Part A applications were delayed for a variety of other reasons, including complex provider ownership structures requiring extensive documentation, contractor staff errors, and difficulty validating Social Security numbers.

Part B applications contractors reported as exceeding timeframes as of July 31, 2005, were primarily the result of one contractor's backlog and providers' failure to respond to requests for information. One Part B contractor reported backlogs of applications waiting to be processed that accounted for an estimated 52 percent of Part B applications reported as exceeding timeframes. This contractor did not provide a specific explanation for the backlog. Forty-one percent of applications reported as exceeding processing timeframes were the result of providers' failure to respond to requests for missing or corrected application information.

Over half of all contractors reported difficulty accessing the PECOS. At the time of our review, 61 percent of contractors (25 of 41) reported receiving frequent, intermittent notices from CMS asking them to use PECOS only during certain time periods. In addition, over half of contractors reported difficulty obtaining and/or recertifying user IDs with PECOS access for their employees. Many contractors reported that these problems caused them difficulty in meeting application-processing timeframes.

CONCLUSION

Our review of the reasons for delayed application processing found that many current Part A applications identified as late had been incorrectly reported as late because of contractor staff misunderstanding of application-processing policy. The applications that were delayed

because of workload backlogs were confined to two large contractors. The changes to the application-processing guidelines implemented in March 2006 specify that processing time does not begin until the contractor receives a complete and correct application. This may reduce the potential for workload backlogs in the future. Finally, over half of all contractors reported difficulty accessing the PECOS.

Based on these findings, we offer to CMS the following suggestions for improvement.

- CMS could conduct updated training for Part A contractor staff to ensure consistent understanding of application-processing policy, specifically regarding when application-processing time ends in relation to receipt of tie-in notices to maintain compliance with the revised "Program Integrity Manual."
- CMS may also want to address issues with system access and user IDs that could lead to future delays in application processing.
- CMS may also want to determine the need for increased system capacity to ensure that periods of limited access to the PECOS will not reoccur as planned initiatives, such as the National Provider Identifier and enrollment of Medicaid providers, are implemented.
- Finally, CMS could revise the Enterprise User Administration Workflow process to prevent user ID requests and recertifications from being denied because of factors such as incorrect approver e-mail addresses, approvers being on leave, or approvers not acting upon e-mails.

AGENCY COMMENTS

CMS indicated in its comments that the information in the report will assist in its ongoing management of the PECOS, but believes that the startup issues noted have been resolved. With regard to training, CMS stated that it has worked with Part A contractors and its own staff to increase understanding of application processing timeframes, specifically with regard to delayed receipt of tie-in notices. With regard to system access and capacity, CMS stated that it has addressed this issue by starting to transition PECOS from a DB2 to an Oracle environment to limit the interference that other CMS applications have

on PECOS. Finally, CMS stated that it will consider more effective ways to improve the Enterprise User Administration Workflow process.

Special Focus Facility ("SFF") Initiative

This webpage offers a list of nursing homes that (a) have had a history of serious quality issues and (b) are included in a special program to stimulate improvements in their quality of care. Please take a minute to review this background information on our "Special Focus Facility" initiative. The background here will help you be as informed as possible when you discuss your long term care options with any nursing home that is listed here – and what they are doing to improve their quality of care.

Background

The Centers for Medicare & Medicaid Services (CMS) and States visit nursing homes on a regular basis to determine if the nursing homes are providing the quality of care that Medicare and Medicaid requires. These "survey" or "inspection" teams will identify deficiencies in the quality of care that is provided. They also identify any deficiencies in meeting CMS safety requirements (such as protection from fire hazards). When deficiencies are identified, we require that the problems be corrected. If serious problems are not corrected, we may terminate the nursing home's participation in Medicare and Medicaid.

Most nursing homes have some deficiencies, with the average being 6-7 deficiencies per survey. Most nursing homes correct their problems within a reasonable period of time. However, we have found that a minority of nursing homes have:

- More problems than other nursing homes (about twice the average number of deficiencies),
- More serious problems than most other nursing homes (including harm or injury experienced by residents), and
- A pattern of serious problems that has persisted over a long period of time (as measured over the three years before the date the nursing home was first put on the SFF list).

Although such nursing homes would periodically institute enough improvements in the presenting problems that they would be in substantial compliance on one survey, significant problems would often re-surface by the time of the next survey. Such facilities with a "yo-yo" or "in and out" compliance history rarely addressed underlying systemic problems that were giving rise to repeated cycles of serious deficiencies. To address this problem CMS created the "Special Focus Facility" (SFF) initiative.

How the Special Focus Facility (SFF) Initiative Works

CMS requires that SFF nursing homes be visited in person by survey teams twice as frequently as other nursing homes (about twice per year). The longer the problems persist, the more stringent we are in the enforcement actions that will be taken. Examples of such enforcement actions are civil monetary penalties ("fines") or termination from Medicare and Medicaid. Within about 18-24 months after a facility is identified by CMS as an SFF nursing home, we expect that there will be one of 3 possible outcomes:

(a) **Improvement & Graduation:** The nursing home graduates from the SFF program because it has made significant improvements in quality of care - and those improvements are continued over time;

(b) **Termination from Medicare:** The nursing home is terminated from participation in the Medicare and Medicaid programs. While such a nursing home may continue to operate (depending on State law), usually it will close once Medicare and Medicaid funding is discontinued. In such a case the State Medicaid Agency (and others) will assist all nursing home residents to transition to another residence that can provide a better and acceptable quality of care. This may include a variety of possibilities, such as another nursing home, a community-based setting, or apartment with good support services.

(c) **Extension of Time:** The nursing home is provided with some additional time to continue in the SFF program because there has been very promising progress, such as the sale of the nursing home to another owner with a much better track record of providing quality care.

How Can You Use This Information

If you are considering admission to a nursing home included on this list you may want to:

- Above all, visit the nursing home. Talk to staff, residents, and other families. You may request to see the results from the last State or CMS survey (it should be in a place that is easily accessible.)
- Before your visit, look at the survey history of the nursing home on *Nursing Home Compare* to see what areas may be problematic.
- Ask the nursing home staff what they are doing to improve the quality of care for residents in the nursing home.
- Call the State survey agency (link to *Nursing Home Compare*) to find out more about the nursing home. Look at the length of time that a nursing home has been on the SFF list. This is particularly important if the nursing home has been an SFF nursing home for more than 18-24 months, since such nursing homes are closer to either graduating (due to improvements) or ending their participation in Medicare and Medicaid.
- Call your local State Ombudsman, Administration on Aging, and local groups to find out more about the nursing home.
- Use the Nursing Home Brochure found at http://www.medicare.gov/Publications/Pubs/pdf/nursinghome.pdf and "Guide to Choosing a Nursing Home" http://www.medicare.gov/Publications/Pubs/pdf/02174.pdf - both publications are available on *Nursing Home Compare*.

If you currently reside in a SFF nursing home, please know that this home is being closely monitored (it is inspected twice as often as other nursing homes). You may also direct any questions you have to the contacts above. The good news is that about 50% of the nursing homes in the SFF program significantly improve their quality of care within 24-30 months after being selected for the SFF initiative, while about 16% tend to be terminated from Medicare and Medicaid.

How to Interpret the Tables

Below we list nursing homes in five (5) different categories:

A. **Table A – New Additions:** Nursing homes newly added to the SFF (which have not yet had a standard survey since being added to the list).

B. **Table B – Not Improved:** Nursing homes that have failed to show significant improvement despite having had the opportunity to show improvement in at least one survey after being named as a SFF nursing home.

C. **Table C – Improving:** Nursing homes that have shown significant improvement, as indicated by the most recent survey, and CMS is waiting to see if the improvement continues over time. If the improvement continues for about 12 months (through two standard surveys), these nursing homes will graduate from the SFF list. "Significant improvement" means that the most recent standard survey (and any later compliant investigations) found no deficiencies in which there was actual harm to any resident, and no deficiency in which there was systemic potential for harm (i.e. no deficiency above an "E" level).

D. **Table D – Recently Graduated:** These nursing homes not only improved, but they sustained significant improvement for about 12 months (through two standard surveys). CMS congratulates these nursing homes and list their names as "graduates" for a few months after they graduate so that anyone who has been tracking their progress will be informed. "Graduation" does not mean that there may not be problems in quality of care, but does generally indicate an upward trend in quality improvement compared to the nursing home's prior history of care.

E. **Table E – No Longer in Medicare and Medicaid:** These are nursing homes that were either terminated by CMS from participation in Medicare and Medicaid within the past few months, or voluntarily chose not to continue such participation. In most cases the nursing homes will have closed, although some nursing homes that leave Medicare later seek to show better quality and re-enter the Medicare program after demonstrating their ability to comply with all Federal health and safety requirements.

Important Note about Information Delays

The State survey agencies are responsible for entering survey information into CMS' databases and providing updates as needed. Every attempt is made to assure the accuracy and timeliness of the information on the list. However, data lags of up to several months can occur between completion of a survey and posting of data on this list. We advise interpreting this information cautiously and supplementing it with information from the ombudsman's office, the State survey agency, or other sources.

Continued Improvements in the Special Focus Facility Initiative

This website is the latest in a series of improvements CMS is making to address the problem of chronically under-performing nursing homes. In 2005, for example, we increased the number of SFF nursing homes by 30% and strengthened enforcement. In November 2007 we began publishing the names of SFF nursing homes that had failed to improve significantly. In February 2008 we added all other SFF nursing homes in a format that allows consumers to distinguish between nursing homes that were improving compared with those that are not. In April 2008 we will add cross-links between the individual nursing home pages on our *NH Compare* website with the full SFF list. In August 2008 we will announce methods by which SFF nursing homes may obtain additional technical assistance to help them improve quality.

Table A - New Additions: These are nursing homes newly added to the SFF initiative (but which have not yet had a standard survey since being added to the list). If you wish to learn more about a specific home, please contact the State survey agency or the Ombudsman's office in your area which can be found in the Helpful Contacts section of *Nursing Home Compare*.

Table B – Not Improved: These are nursing homes that have failed to show significant improvement despite having had the opportunity to show improvement in at least one survey after being named a SFF nursing home.

Table C - Improving: These are nursing homes that have show significant improvement, as indicated by the most recent survey, and CMS is waiting to see if the improvement continues over time. If the improvement continues, these nursing homes will graduate from the SFF list.

Table D – Recently Graduated: These are nursing homes that not only improved, but they sustained significant improvement for about 12 months (through two surveys). We congratulate these nursing homes and list their names as "graduates" for a few months after they graduate so that anyone who has been tracking their progress will be informed.

Table E – No Longer in Medicare and Medicaid: These are nursing homes that were either terminated by CMS from participation in Medicare and Medicaid within the past few months, or voluntarily chose not to continue such participation. In most cases the nursing homes will have closed, although some nursing homes that leave Medicare later seek to show better quality and re-enter the Medicare program after demonstrating their ability to comply with all Federal health and safety requirements.

Table A: Facilities Newly Added to the Program

Facility Name	Address	City	State	Zip	Phone Number	Most Recent Survey	Months as SFF
Plaza Heathcare	1475 North Granite Reef Rd	Scottsdale	AZ	85257	480-990-1904		0
Martinez Convalescent	4110 Alhambra Way	Martinez	CA	94553	925-228-4260		5
Delmar Nursing And Rehabilitation Center	101 E. Delaware Avenue	Delmar	DE	19940	302-846-3077		0
Bay Center	1336 St. Andrew Boulevard	Panama City	FL	32405	850-763-3911		0
Pocatello Care And Rehab	527 Memorial Drive	Pocatello	ID	83201	208-478-3333		3
Medicalodge Of Leavenworth	1503 Ohio St	Leavenworth	KS	66048	913-772-1844		0
Baptist Convalescent Center	120 Main Street	Newport	KY	41071	859-581-1938		7
Lake Charles Care Center	2701 Ernest Street	Lake Charles	LA	70601	337-439-0336		2
Redstone Rehabilitation And Nursing Center	135 Benton Drive	East Longmeadow	MA	1028	413-525-3336		1
Waldorf Center	4140 Old Washington Highway	Waldorf	MD	20602	301-645-2813		0
Marshall Health Care & Rehab	9 Beal Street	Machias	ME	4654	207-255-3387		3
Infinia At Owatonna	201 Southwest 18th Street	Owatonna	MN	55060	507-451-6800		3
Woodbury Health Care Center	7012 Lake Road	Woodbury	MN	55125	651-735-6000		2
Evergreen Livingston	510 S 14th St	Livingston	MT	59047	406-222-0672		5
Brookstone Living Center	8990 Hwy 17 South , Po Box 429	Pollocksville	NC	28573	252-224-0112		1
Forest View Rehabilitation Center	5935 Mount Sinai Road	Durham	NC	27705	919-489-2361		1
Rock View Good Samaritan Center	314 3rd Avenue Ne	Parshall	ND	58770	701-862-3138		4
Lakeview Care Center	P O Box 8, 404 East 8th Street	Firth	NE	68358	402-791-5588		4
Good Samaritan Society Artesia	1402 West Gilchrist Avenue	Artesia	NM	88210	575-746-9865		1
Evergreen Valley Nursing Home	8 Bushey Boulevard	Plattsburgh	NY	12901	518-563-3261		2
Williamsville Suburban	163 South Union Road	Williamsville	NY	14221	716-632-6152		3
Chickasha Nursing Center	2700 South 9th Street	Chickasha	OK	73018	405-224-3593		5
Evergreen The Dalles	1023 W. 25th Avenue	The Dalles	OR	97058	541-298-5158		1
Golden Living Center - West Shore	770 Poplar Church Road	Camp Hill	PA	17011	717-763-7070		2
Haven Health Center Of Pawtucket	70 Gill Avenue	Pawtucket	RI	2861	401-722-7900		3
Cottonwood Nursing And Rehabilitation Center	2224 N Carroll Blvd	Denton	TX	76201	940-387-6656		2
Southeast Nursing And Rehab	4302 E Southcross	San Antonio	TX	78222	210-333-1223		2
Mt. Ogden Health And Rehabilitation Center	375 East 5350 South	Ogden	UT	84405	801-479-5700		5
Beacon Shores Nursing & Rehabilitation	340 Lynn Shores Drive	Virginia Beach	VA	23452	757-340-6611		4
North Auburn Rehab And Health Center	2830 I Street Northeast	Auburn	WA	98002	253-833-1260		2

Updated April 23, 2008

Table B: Facilities That Have Not Improved

Facility Name	Address	City	State	Zip	Phone Number	Most Recent Survey	Months as SFF
Woodley Manor Health & Rehabilitation	3312 Woodley Road	Montgomery	AL	36116	334-288-2780	3/6/2008	14
Medi-Home, Inc	4623 Rogers Avenue	Fort Smith	AR	72903	479-452-1541	10/13/2007	7
Infinia At Show Low	2401 East Hunt Street	Show Low	AZ	85901	928-537-5333	1/23/2008	3
Golden Cross Health Care Of Fresno	1233 A Street	Fresno	CA	93706	559-268-6317	2/5/2008	6
Santa Cruz Skilled Nursing Center (Formerly Pleasant Care Santa Cruz)*	2990 Soquel Avenue	Santa Cruz	CA	95062	831-479-6950	10/16/2007	22
Eagle Ridge At Grand Valley	2425 Teller Avenue	Grand Junction	CO	81501	970-243-3381	1/9/2008	39
Kindred Healthcare & Rehab Ctr Of Northglenn	401 Malley Drive	Northglenn	CO	80233	303-452-4700	9/13/2007	39
Key West Convalescent Center	5860 W Junior College Road	Key West	FL	33040	305-296-2459	3/13/2008	39
Signature Healthcare Of Marietta	811 Kennesaw Avenue	Marietta	GA	30060	770-422-2451	3/19/2008	26
Cedar Falls Health Care Center	1728 West Eighth Street	Cedar Falls	IA	50613	319-277-2437	1/18/2008	6
Polk City Nursing And Rehabilitation Center	1002 West Washington Avenue	Polk City	IA	50226	515-984-6511	12/21/2007	14
Embassy Health Care Center	555 West Kahler	Wilmington	IL	60481	815-476-2200	11/9/2007	8
Harrisburg Care Center	1000 West Sloan Street	Harrisburg	IL	62946	618-252-3905	3/3/2008	3
St Joseph Care Center - West	4600 W Washington Ave	South Bend	IN	46619	574-282-1294	10/25/2007	11
Valparaiso Care And Rehabilitation Center	606 Wall St	Valparaiso	IN	46383	219-464-4976	12/19/2007	39
Deseret Nursing And Rehabilitation At Colby	105 East College Drive	Colby	KS	67701	785-462-6721	11/15/2007	14
Cambridge Place	2020 Cambridge Drive	Lexington	KY	40504	859-252-6747	2/8/2008	15
Harborside Healthcare Wakefield	One Bathol Street	Wakefield	MA	1880	781-245-7600	1/22/2008	14
Piety Corner	325 Bacon Street	Waltham	MA	2154	781-894-5264	1/17/2008	3
Manor Care Rossville	6600 Ridge Road	Baltimore	MD	21237	410-574-4950	1/29/2008	3
Imperial Healthcare Centre	26505 Powers Ave	Dearborn Heights	MI	48125	313-291-6200	11/9/2007	25
Metron Of Big Rapids	725 W Fuller	Big Rapids	MI	49307	231-796-2631	11/16/2007	11
Senior Estates	2323 Swope Parkway	Kansas City	MO	64130	816-924-1122	3/10/2008	24
Evergreen Missoula Health & Rehab	3018 Rattlesnake Dr	Missoula	MT	59802	406-549-0988	12/12/2007	39
Infinia At Florence Heights	3110 Scott Circle	Omaha	NE	68112	402-455-6636	10/3/2007	39
Epsom Healthcare Center	901 Suncook Valley Highway	Epsom	NH	3234	603-736-4772	2/7/2008	3
Palace Rehabilitation And Care Center	Rt 38 And Mill Road	Maple Shade	NJ	8052	856-779-1500	4/9/2008	39
Victoria Health Care Center	40 Freneau Avenue	Matawan	NJ	7747	732-765-5600	1/9/2008	15
Vivian Teal Howard Rhcf	116 East Castle Street	Syracuse	NY	13205	315-475-1641	3/3/2008	18
Briarfield At The Ridge	3379 Main Street	Mineral Ridge	OH	44440	330-652-9901	2/28/2008	16
Geriatric Center Of Mansfield	50 Blymyer Ave	Mansfield	OH	44903	419-774-5100	11/29/2007	13
White Oak Manor	1926 Ridge Avenue	Warren	OH	44484	330-369-4672	3/12/2008	5
Woodlawn Health Care & Rehab	535 Lexington Avenue	Mansfield	OH	44907	419-756-7111	12/13/2007	13
Northwest Nursing Center	2801 Northwest 61st Street	Oklahoma City	OK	73112	405-842-6601	10/31/2007	17
Ashton Hall Nursing And Rehab	2109 Red Lion Road	Philadelphia	PA	19115	215-673-7000	3/4/2008	39
Hometown Nursing And Rehab Cen	149 Lafayette Avenue	Tamaqua	PA	18252	570-668-1775	10/19/2007	22
Brighten At Broomall*	43 Church Lane	Broomall	PA	19008	610-356-3003	1/15/2008	22
Overton Park Health Care (Wtro)	131 N Tucker	Memphis	TN	38104	901-726-5600	12/12/2007	14
Benner Healthcare Center	3510 Sherman St	Houston	TX	77003	713-224-5344	1/10/2008	11
San Saba Nursing Home, Inc	608 S Edgewood	San Saba	TX	76877	325-372-5179	12/19/2007	11
Taylor Care Center	212 E Lake Dr	Taylor	TX	76574	512-365-8856	10/5/2007	11
Berlin Health And Rehabilitation Center	98 Hospitality Drive	Barre	VT	5641	802-229-0308	2/21/2008	12
Franklin Hills Health & Rehab	North 6021 Lidgerwood	Spokane	WA	99207	509-489-3323	10/26/2007	22
Frontier Rehab & Extended Care	1500 3rd Avenue	Longview	WA	98632	360-423-8800	1/16/2008	39
Middleton Village	6201 Elmwood Ave	Middleton	WI	53562	608-831-8300	1/31/2008	4
Eagle Pointe	1600 27th Street	Parkersburg	WV	26101	304-485-6476	2/28/2008	5

*Check with State Agency for current status.

Updated April 23, 2008

Table C: Facilities That Have Shown Improvement

Facility	Address	City	State	Zip	Phone Number	Most Recent Survey	Months as SFF
Eastview Health Care Center	7755 Fourth Avenue South	Birmingham	AL	35206	205-833-0146	3/13/2008	14
Bensons Nursing Home	1315 South Hutchinson Street	Nashville	AR	71852	870-845-4933	10/11/2007	14
Heritage Rehabilitation Center	21414 S. Vermont Avenue	Torrance	CA	90502	310-320-8714	1/30/2008	5
Kern Valley Healthcare Dp/Snf	6412 Laurel Ave	Lake Isabella	CA	93240	760-379-2681	2/29/2008	5
Yuba City Care Center	1220 Plumas Street	Yuba City	CA	95991	530-671-0550	12/13/2007	11
Chelsea Place Care Center	25 Lorraine St	Hartford	CT	6105	860-233-8241	11/7/2007	13
Wethersfield Health Care Ctr	341 Jordan Lane	Wethersfield	CT	6109	860-563-0101	2/7/2008	39
Carolyn Boone Lewis Health Care Center	1380 Southern Ave Se	Washington	DC	20032	202-279-5880	12/6/2007	39
Apollo Health And Rehab	1000 24th St N	Saint Petersburg	FL	33713	727-323-4711	2/28/2008	14
Horizon Health Care Daytona Beach	1350 S Nova Rd	Daytona Beach	FL	32114	386-258-5544	10/26/2007	14
Palms Rehabilitation And Nursing Center	3370 Nw 47th Terrace	Lauderdale Lakes	FL	33319	954-733-0655	12/6/2007	18
Blair House Nursing & Rehabilitation Center	2541 Milledgeville Road	Augusta	GA	30904	706-738-2581	2/20/2008	5
Place At Augusta, The	820 Stevens Creek R0ad	Augusta	GA	30907	706-860-6622	2/27/2008	39
Leahi Hospital	3675 Kilauea Avenue	Honolulu	HI	96816	808-733-8000	1/31/2008	18
Blair House	1212 Indian Hills Drive	Burlington	IA	52601	319-752-4100	10/4/2007	39
The Abington On Grand	3440 Grand Avenue	Ames	IA	50010	515-232-3426	9/21/2007	39
Alden Park Strathmoor	5668 Strathmoor Drive	Rockford	IL	61107	815-229-5200	10/24/2007	39
Berkshire Nursing & Rehab	8200 West Roosevelt Road	Forest Park	IL	60130	708-488-9850	2/7/2008	34
International Village	4815 South Western Ave	Chicago	IL	60609	773-927-4200	1/28/2008	39
Harborside Healthcare - Indianapolis	8201 W Washington St	Indianapolis	IN	46231	317-244-6848	3/13/2008	2
Hillcrest Centre For Health And Rehab	203 Sparks Avenue	Jeffersonville	IN	47130	812-283-7918	2/15/2008	12
Ottawa Retirement Village	1100 W 15th St	Ottawa	KS	66067	785-242-5399	1/17/2008	34
Highlands Nursing & Rehabilitation Center	1705 Stevens Avenue	Louisville	KY	40205	502-451-7330	3/19/2008	17
Lake Providence Subacute	5976 Hwy 65 North	Lake Providence	LA	71254	318-559-4050	10/31/2007	14
Rayville Nursing And Rehab Center	294 Hwy 3048	Rayville	LA	71269	318-728-2089	1/17/2008	5
Cedar Hill Healthcare Center	49 Thomas Patten Drive	Randolph	MA	2368	781-961-1160	3/11/2008	14
Sandy River Center	119 Livermore Falls Rd	Farmington	ME	4938	207-778-6591	1/17/2008	3
Fairlane Senior Care And Rehab Center	15750 Joy	Detroit	MI	48228	313-273-6850	2/8/2008	20
Manor Of Northwest Detroit Skilled Nursing And Rehabilitation	16181 Hubbell St	Detroit	MI	48235	313-273-8764	10/19/2007	25
Golden Valley Rehabilitation And Care Center	7505 Country Club Drive	Golden Valley	MN	55427	763-545-0416	12/6/2007	13
Mcintosh Manor	700 Northeast Riverside Avenue	Mcintosh	MN	56556	218-563-2715	11/16/2007	39
Jefferson City Nursing And Rehabilitation	1221 Southgate Lane	Jefferson City	MO	65109	573-635-3131	3/13/2008	2
Madison Medical Center	611 West Main Street, Po Box 431	Fredericktown	MO	63645	573-783-3341	2/27/2008	4
Parkside Manor	1201 Hunt Avenue	Columbia	MO	65202	573-449-1448	2/28/2008	24
Hinds County Nursing & Rehabilitation Ctr Llc	3454 Albermarle Rd	Jackson	MS	39213	601-362-5394	9/7/2007	23
Reginald P White Nursing Facility	1451 &1455 North Lakeland Drive/Po Box 4128	Meridian	MS	39307	601-581-0135	1/17/2008	23
Sunbridge Care & Rehab/Triad	707 North Elm Street	High Point	NC	27262	336-885-0141	12/13/2007	39
Carney's Point Care Center	201 Fifth Avenue	Carneys Point	NJ	8069	856-299-6800	3/7/2008	39
Evergreen Mountainview Health	201 Koontz Lane	Carson City	NV	89701	775-883-3622	10/19/2007	39
Harbour Health Multicare Center	1205 Delaware Avenue	Buffalo	NY	14209	716-885-3838	10/3/2007	9
Northwoods Rehab At Hilltop	1805 Providence Avenue	Niskayuna	NY	12309	518-374-2212	3/13/2008	9
Oak Hills Pavilion	4307 Bridgetown Road	Cheviot	OH	45211	513-598-8000	2/15/2008	6

Updated April 23, 2008

Table C: Facilities That Have shown Improvement

Facility	Address	City	State	Zip	Phone Number	Most Recent Survey	Months as SFF
Village Manor	2060 Ne 238th Drive	Troutdale	OR	97060	503-491-0553	2/19/2008	4
Manor At Susquehanna Village	990 Medical Road	Millersburg	PA	17061	717-692-4751	12/6/2007	8
Countrywood Nursing Center	1645 Ridge Road	Hopkins	SC	29061	803-776-3873	12/19/2007	39
Unihealth Post Acute Care Of Moncks Corner, Llc.	505 South Live Oak Drive	Moncks Corner	SC	29461	843-761-8368	2/13/2008	39
Aberdeen Healthcare Center	1700 North Highway 281	Aberdeen	SD	57401	605-225-7315	12/6/2007	10
Bennett County Hospital And Nursing Home	102 Major Allen, Po Box 70-D	Martin	SD	57551	605-685-6586	2/13/2008	10
Hillview Health Care (Etro)	1666 Hillview Drive	Elizabethton	TN	37643	423-542-5061	4/2/2008	14
River Park Healthcare Center (Mtro)	1306 Katie Avenue	Nashville	TN	37207	615-228-3494	1/30/2008	4
The Renaissance At Kessler Park	2428 Bahama Dr	Dallas	TX	75211	214-948-3811	3/14/2008	39
Harbour Pointe M & R Center	1005 Hampton Blvd	Norfolk	VA	23507	757-623-5602	11/2/2007	39
Ruxton Health Of Woodbridge	14906 Jefferson Davis Highway	Woodbridge	VA	22191	703-491-6167	2/29/2008	23
Columbus Nursing And Rehab	825 Western Ave	Columbus	WI	53925	920-623-2520	2/27/2008	9
Luther Home	831 Pine Beach Rd	Marinette	WI	54143	715-732-0155	1/31/2008	39
Willows Nur And Rehab	41 Rickel Rd	Sun Prairie	WI	53590	608-837-8529	3/5/2008	15
Heartland Of Clarksburg	100 Parkway Drive	Clarksburg	WV	26301	304-624-6401	9/6/2007	39
Mountain Towers Healthcare Center	3128 Boxelder Drive	Cheyenne	WY	82001	307-634-7901	10/25/2007	10

Updated April 23, 2008

Table D: Facilities That Have Recently Graduated from the SFF Program

Facility Name	Address	City	State	Zip	Phone Number	Most Recent Survey	Months as SFF
Arbors At New Castle	32 Buena Vista Drive	New Castle	DE	19720	302-328-2580	3/27/2008	39
Emerald Shores	626 North Tyndall Parkway	Calloway	FL	32404	850-871-6363	2/29/2008	14
Ben Hur Home	1371-1375 S Grant Avenue	Crawfordsville	IN	47933	765-362-0905	1/29/2008	39
Atchison Senior Village	1419 N 6th St	Atchison	KS	66002	913-367-1905	3/11/2008	39
Plaquemine Caring	59215 River West Drive	Plaquemine	LA	70764	225-687-0240	1/17/2008	14
Heartland Healthcare	6500 Riggs Road	Hyattsville	MD	20783	301-559-0300	2/15/2008	18
Clemmons Nursing & Rehab	3905 Clemmons Road	Clemmons	NC	27012	336-766-9158	2/21/2008	19
Liberty Nursing & Rehab Of Mecklenberg County	3700 Shamrock Dr	Charlotte	NC	28215	704-940-8300	2/7/2008	9
Universal Healthcare/North Raleigh	5201 Clarks Fork Drive	Raleigh	NC	27616	919-872-7033	2/21/2008	9
William Clough Ecu	273 County Road	New London	NH	3257	603-526-5312		9
Pawhuska Nursing Home, Llc	1228 South Pecan	Pawhuska	OK	74056	918-287-3940	3/12/2008	39
Rose Linn Care Center	2330 Debok Road	West Linn	OR	97068	503-655-0474	1/7/2008	11
Latrobe Regional	576 Fred Rogers Drive	Latrobe	PA	15650	724-537-4441	2/14/2008	9
Edgewood Manor	4925 Elizabeth St	Texarkana	TX	75503	903-793-4645	2/27/2008	39
Oak Crest Nursing Center	1902 Fm 3036	Rockport	TX	78382	361-729-9971	1/18/2008	11

Table E: Facilities No Longer Participating in the Medicare and Medicaid Program

Facility Name	Address	City	State	Zip	Phone Number	Most Recent Survey	Months as SFF
Evergreen Foothills Health And Rehabilitation Cent	15810 South 42nd St.	Phoenix	AZ	85048	480-759-0358	12/28/2007	39
Ember Care Pamona	1550 North Park Ave.	Pomona	CA	91768	909-623-0791	9/19/2007	22
Gooding Rehab & Living Ctr	1220 Montana Street	Gooding	ID	83330	208-934-5601	9/20/2007	39
St Elizabeth Healthcare And Rehabilitation Center	11400 Mehl Avenue	Florissant	MO	63033	314-741-3525	9/17/2007	24
Fort Bayard Medical Center	100 Calle El Centro	Fort Bayard	NM	88036	505-537-3302	12/4/2007	39
Evergreen Centralia	1015 Long Road	Centralia	WA	98531	360-736-3381	9/11/2007	10

Updated April 23, 2008

2008
Action Plan for
(Further Improvement of)
Nursing Home Quality

2008

Executive Summary

About 1.5 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*. Those individuals, and an even larger number of their family members, friends, and relatives, must be able to count on nursing homes to provide reliable care of consistently high quality.

The Centers for Medicare & Medicaid Services (CMS) establishes quality of care standards and conditions of participation for the Medicare and Medicaid programs. Such requirements are carefully crafted to highlight key areas of quality and convey basic, enforceable expectations that nursing homes must meet. More than 4,000 Federal and State surveyors conduct on-site reviews of every nursing home at least once every 15 months (and about once a year on average). CMS also contracts with quality improvement organizations (QIOs) to assist nursing homes to make vital improvements in an increasingly large number of priority areas. Additionally, CMS supports the Health and Human Services Economic Impact of Health Care Regulations. The goal of this project is to examine the economic impact of major Federal regulations governing the health care industry and identify strategies for simplifying them, while maintaining the highest quality health care and other resident protections.

The most effective approach to ensure quality is one that mobilizes all available tools and aligns them in a comprehensive strategy. This action plan summarizes our comprehensive strategy. It consists of five inter-related and coordinated approaches:

A. ***Consumer Awareness and Assistance:*** Elderly individuals, people who have a disability, their families, friends, and neighbors are all essential participants in ensuring the quality of care in any health care system. The availability of relevant, timely information can significantly help such individuals to be active, informed participants in their care. This information also can increase the ability of such individuals to hold the health care system accountable for the quality of services and support that should be provided. To that end, CMS seeks to provide an increasing array of understandable information that can be readily accessed by the public. The CMS Web site, www.Medicare.gov, features "Nursing Home Compare" as well as other important information and education resources for consumers, families, and friends.

B. ***Survey, Standards, and Enforcement Processes:*** During 2008, we will undertake several initiatives to improve the effectiveness of the annual nursing home surveys, as well as the investigations that are prompted by complaints from consumers or family members about nursing homes.

C. ***Quality Improvement:*** We are promoting a program of quality improvement in a number of key areas. These areas include reduction in the extent to which restraints are used in nursing homes, reduction in the prevalence of preventable pressure sores that threaten the health and well-being of a significant number of nursing home residents, and the Agency's participation in part of a national movement known as "culture change." The principles behind culture change echo OBRA principles of knowing and respecting each nursing home resident and providing

individualized care that best enhances each resident's quality of life. The culture change movement encourages facilities to examine and transform their organization's values, structures and practices to transform the traditional institutional approach to care delivery into one that is person directed, and responds to what each person wants and needs.

D. ***Quality Through Partnerships:*** No single approach or actor can fully assure quality. We must combine, coordinate, and mobilize many actors and many techniques through a partnership approach. The QIOs, State survey agencies, and others are committed to such a common endeavor. The differences in their responsibilities remain, but their distinct roles can be coordinated in a number of appropriate ways to achieve better results than can be achieved by any one actor alone. In addition, we plan to strengthen our partnerships with non-governmental organizations who are also committed to quality improvement in nursing homes. In May 2006, we began partnering with stakeholders to design and then facilitate the *Advancing Excellence in America's Nursing Homes* Campaign. The unprecedented, collaborative campaign seeks to better define quantitative goals in nursing home quality improvement. The purpose of this Campaign is to align the strategies of the many partners who have expressed their commitment to excellent nursing home quality.

E. ***Value-Based Purchasing:*** As the largest purchaser of nursing home services (about $64 billion per year), States and CMS exert leverage to insist on basic levels of quality. "Purchasing power" is an important tool that might be more effectively employed to promote quality in the future. The Nursing Home Value-Based Purchasing Demonstration is intended to augment and reinforce other quality efforts by ensuring that financial investments made by nursing homes to improve quality will be met by payment methods that can discern the difference between excellent, mediocre, and poor quality. The Post Acute Care Instrument Development & Demonstration implements the Deficit Reduction Act of 2005 mandate for a demonstration that supports post-acute care payment reform.

CMS Nursing Home Quality Milestones: CMS highlighted some key dates in its testimony before the Senate Special Committee on Aging Chairman on November 15, 2007.

Milestones Planned for Additional CMS Action in Nursing Home Quality[1]

Time	Actions
November 2007	**Advancing Excellence Campaign:** CMS, advocacy organizations, foundations, nursing homes, and other sponsorws a national conference to improve nursing home care and expand the campaign for *Advancing Excellence in America's Nursing Homes* (see www.nhqualitycampaign.org)
December 2007	**Special Focus Facilities (SFFs):** CMS posts on CMS' *Nursing Home Compare* website (at www.medicare.gov) the names of SFF nursing homes that have failed to improve significantly.
January 2008	**Budget**: Congress endorses (hopefully) the President's 2008 budget request for survey & certification, improving the Medicare quality assurance program.

[1] This is a sample of some of the milestones. For additional information see CMS' Nursing Home Action Plan published each year at http://www.cms.hhs.gov/CertificationandCompliance/12_NHs.asp#TopOfPage

Action Plan for Further Improvement of Nursing Home Quality

February 2008	**Quality Indicator Survey (QIS)**: CMS adds one State to the 5 States that fully implements the new, improved Medicare survey process for nursing homes. This major new system has been in development for many years and is now being implemented gradually within existing budget limits.
March 2008	**Value-Based Purchasing:** CMS issues a solicitation to begin the process of inviting States and nursing homes to participate in a demonstration program in which payment is adjusted in a manner to recognize improvements in nursing home quality.
April 2008	**Culture Change:** CMS co-sponsors a national symposium, "Creating Home," to promote culture change and improvement in quality.
May 2008	**Background Checks:** CMS finalizes evaluation of 3-year pilot program demonstrating a comprehensive system of criminal and other background checks before nursing homes hire prospective new employees.
June 2008	**Pressure Ulcers and Restraints Reduction:** CMS publishes information on the national efforts to reduce the incidence of pressure ulcers in nursing homes and reduce the use of restraints.
July 2008	**Better Survey Guidance:** CMS publishes new guidance to surveyors on nutrition.
August 2008	**Fire-Safety Protection:** CMS publishes final rule requiring all nursing homes to be fully spinklered by the end of a specified phase-in period.
August 2008	**Quality Improvement Organizations:** New CMS contract sets forth an ambitious 3-year agenda for QIOs to work with nursing homes that have poor quality, including Special Focus Facilities (subject to OMB approval).
September 2008	**Staffing Information:** CMS issues draft methodologies to improve the accuracy of staffing information submitted by nursing homes and posted on the CMS Web site (Nursing Home Compare at www.medicare.gov)
October 2008	**Escrows Accounts for CMPs**: CMS advances for possible inclusion in the President's budget a call for legislation that would permit the collection and escrow deposit of civil monetary penalties (CMPs) if appealed.

Table of Contents

Executive Summary i

Table of Contents iv

Purpose 1

Action Plan 1

A. Consumer Awareness and Assistance 2

1. Improving Staffing Data on the CMS Web Site 2
2. Develop Nursing Home Staffing Quality Measure, Phase 2 3
3. Develop Immunization Measures in Nursing Homes for Public Reporting 3

B. Survey, Standards, and Enforcement Processes 4

1. CMS Background Check Pilot: Preventing Abuse and Neglect 4
2. Improving Fire Safety in Nursing Homes 5
3. Interpretive Guidance to Surveyors 6
4. Refinement of State Performance Standards 6
5. Federal Comparative Validation Surveys 8
6. Improved Surveys Via the "Quality Indicator Survey (QIS)" 8
7. Establishment of Escrow Accounts for Civil Monetary Penalties 9
8. Monitor Civil Monetary Penalty Amounts 9
9. Special Focus Facilities 10
10. Update Nursing Home Nurse Aide Training Curriculum 11
11. Training 11

C. Quality Improvement 13

1. Government Performance and Results Act (GPRA) Goals 13
2. Development and Validation of MDS 3.0 14
3. Data Assessment and Verification Contract (DAVE) 2: MDS 2.0 15
4. STRIVE National Nursing Home Time Study 16
5. Study of State Feeding Assistant Programs 17
6. Working with Quality Improvement Organizations 18
7. Expansion of Collaborative Focus Facility (CFF) Project 19
8. Culture Change 20

D. Quality Approaches Through Partnerships 21

1. Quarterly Meetings with States 22

2. Leadership Summit....22
3. Communicating with Other Stakeholders....22
4. Advancing Excellence in America's Nursing Homes Campaign....22
5. Medicare Quality Improvement Community (MedQIC)....24
6. Emergency Preparedness in Nursing Homes....25
7. Long-Term Care Task Force....26
8. Long-Term Care Rebalancing....26

E. Value-Based Purchasing....27

1. Design Nursing Home Value-Based Purchasing Demonstration....27
2. Post-Acute Care Instrument Development & Demonstration....28

Action Plan for Further Improvement of Nursing Home Quality

Purpose

In this report we set forth our action plan for the continued improvement of quality in nursing homes. Five coordinated sets of actions make up our comprehensive strategy:

1. Consumer Awareness and Assistance
2. Survey, Standards, and Enforcement Processes
3. Quality Improvement
4. Quality Approaches Through Partnerships
5. Value-Based Purchasing

Action Plan

In the past 10 years, the Centers for Medicare & Medicaid Services (CMS) and the States have made progress in holding nursing homes accountable for meeting health and safety standards and improving care. In the process CMS has:

- Revised the survey process and guidelines to better focus on quality of care, quality of life, and the prevention of abuse and neglect;
- Strengthened enforcement responses to non-compliant nursing homes;
- Provided better information to help consumers make decisions on choosing a nursing home;
- Developed and reported on quality measures, such as the prevalence of pressure ulcers, incontinence, and physical restraints;
- Worked with quality improvement organizations (QIOs) to assist nursing homes in meeting health and safety requirements;
- Built improved infrastructure for the survey and certification system, such as a new ASPEN Complaint Tracking System (ACTS) and the ASPEN Enforcement Manager (AEM) to identify and track needed improvements in the quality of care;
- Provided satellite training on many topics that are available to providers via download; and
- Tested and evaluated prospective improvements to the survey process.

Based on our own analysis, input from Congress, comments from our stakeholders, and work from both the Government Accountability Office (GAO) and the Department of Health and Human Services (DHHS) Office of Inspector General, it is clear that further refinements and new initiatives are essential in order to ensure that nursing home residents can count on adequate support and services in a caring and safe environment.

The themes outlined in this action plan will guide CMS efforts to continue progress in improving the nursing home survey and certification program. We invite public comment on this action plan and welcome the opportunity to discuss with all stakeholders the various methods by which we can

work together to ensure optimum services and support, in all settings, for our Nation's elderly and disabled. Please submit comments to Ms. Kathleen Wilson, Ph.D., at kathleenwilson@verizon.net.

A. Consumer Awareness and Assistance

Elderly individuals, people who have a disability, their families, friends, and neighbors are all essential participants in ensuring the quality of care in any health care system. The availability of relevant, timely information can significantly help such individuals to be active, informed participants in their care. Such information can also increase the ability of such individuals to hold the health care system accountable for the quality of services and support that should be provided. To that end, CMS seeks to provide an increasing array of understandable information about nursing homes that can be accessed readily by the public. The CMS Web site, www.Medicare.gov, features "Nursing Home Compare" (NHC) as well as other important information for consumers, families, and friends. Companion CMS Web sites, such as "Home Health Compare" and the President's *New Freedom Initiative (www.cms.hhs.gov/NewFreedomInitiative/)*, offer useful information regarding non-institutional alternatives.

We continuously seek to improve the usefulness of information on our Web sites and will make the following improvements on the NHC Web site in 2008.

1. **Improving Staffing Data on the CMS Web Site**—The extent to which a nursing home adequately staffs its facility is a critical factor in the quality of care residents receive. For this reason, CMS publishes information about the staffing in each nursing home on Nursing Home Compare (NHC). Because the information is self-reported by nursing homes and has certain limitations, CMS cautions users to view the information with care and only in the context of many other factors (more specifically, family visits to nursing homes in their area).

   In order to provide more accurate consumer information about nursing home staffing, CMS implemented in fiscal year (FY) 2005, a stronger "edit and correction system" to the data that are ultimately placed on NHC. Under this system, information sent by nursing homes is reviewed by CMS. Information that is questionable is sent to the State survey agency (SA) for confirmation or correction. CMS also improved the display of information so that it is more understandable to consumers and consistent with the latest research. Activities during FY 2006 and FY 2007 were directed toward further improvements in the accuracy and comprehensiveness of information on NHC. That work will continue into FY 2008.

   As part of a longer term plan to increase the accuracy and comprehensiveness of the staffing data, CMS has been investigating the feasibility of the use of payroll data as a basis for the information on NHC. Payroll data could be used to calculate measures of staff turnover and staff retention in addition to supporting more accurate calculation of the staffing measures currently posted. Specifications for electronic submission of a payroll data extract file for each nursing home have been produced and conversations with payroll vendors and nursing facilities to determine the feasibility and level of burden of electronic submission currently are underway. In FY 2008, CMS will: (a) complete the assessment of the feasibility of use of a payroll database extract; (b) accomplish a management review of the electronic

submission of staffing data, including the costs and burdens of moving to this kind of a system; and (c) after management sign-off, publish a Notice of Proposed Rulemaking to initiate use of this system.

The action steps described below will result in a broader range of more accurate and easier-to-understand information for consumers about staffing levels and staff turnover in nursing facilities.

Action Plan	Date
Finish the feasibility test of the use of an electronic payroll data extract file.	Fall 2007
Continue working with the Nursing Home Value-Based Purchasing Demonstration to implement a payroll database system for the demonstration.	Spring 2008
After CMS management review, consider publication of a Notice of Proposed Rulemaking.	Winter 2008-2009
Continue work with the Division of National Systems to refine computer system capacity needs for implementation of the electronic submission of payroll data.	Summer 2008

2. **Develop Nursing Home Staffing Quality Measure, Phase 2**— The National Quality Forum is developing and implementing a national strategy for health care quality measurement and reporting. In 2003, the Forum has recommended that CMS include a nurse-staffing quality measure in the set of measures that are publicly reported on Nursing Home Compare. CMS began measurement development efforts in Fall 2003. Phase I of CMS' efforts included review and analysis of the relevant literature, consultation with experts in the field, exploration of options for collecting staffing data, assembly of a research data file as a basis for measurement development, and construction of draft measures. Phase 2 of the project consists of analysis of the use of contract staff, validation of the draft quality measures and consideration of appropriate case-mix and/or risk adjustment. CMS plans to submit the staffing quality measures developed in this project to the National Quality Forum consensus review process.

Action Plan	Date
Conduct analysis of contract staff hours.	Fall 2007
Validate draft staffing quality measures against quality outcome data.	Fall 2007
Produce a draft measure of staff immunization for influenza.	Winter 2008
Draft case-mix adjustment plan.	Summer 2008

3. **Develop Immunization Measures in Nursing Homes for Public Reporting**— *Healthy People 2010* set objectives for nursing home resident immunization of 90 percent for both

influenza and pneumococcal vaccines. In support of reaching that goal, a national quality improvement initiative is underway that will ensure all nursing facility residents are offered and, where appropriate, receive influenza and pneumococcal vaccinations.

In October 2005, nursing homes began collecting data on the influenza and pneumococcal immunization status of their residents through new items in the Minimum Data Set (MDS), Section W. These data will not only help bring residents eligible for immunization to the attention of nursing home staff, but will help nursing facilities, Quality Improvement Organizations, State survey agencies, and State and local health departments monitor immunization rates.

In October 2006, CMS began publishing facility-level influenza and pneumococcal immunization rates on the Nursing Home Compare Web site so consumers also have access to this quality of care information.

Action Plan	Date
Conduct first analysis of data from immunization rates measure.	Spring 2008

B. Survey, Standards, and Enforcement Processes

We will undertake several initiatives during 2008 to improve the effectiveness of the annual nursing home surveys, as well as the investigations that are prompted by complaints from consumers or family members about nursing homes.

1. **CMS Background Check Pilot: Preventing Abuse and Neglect**— Nursing home residents have a right, by law, to be free from abuse, neglect, or misappropriation of their own funds. A competent and caring workforce is instrumental in fulfilling these legal rights. Effective recruitment, screening, supervision, and training of workers (as well as supervisors) are essential to ensuring a viable workforce.

   In 2005, in accordance with section 307 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS selected seven States (Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico, and Wisconsin) to pilot a program to determine the most efficient, effective, and economical methods for conducting State and national background checks and searches of relevant registries for screening applicants who would have direct access to patients and residents in nursing homes and other long-term care (LTC) providers. Three States (Alaska, Michigan and Wisconsin) received additional funding to deliver a comprehensive training program designed to prevent abuse or neglect by LTC workers. CMS established a technical assistance contract to assist the States with implementing their pilot programs, and an additional contract was established to conduct a neutral evaluation of the results of the background check pilot programs. The pilot State's ability to use grant funding for their background check and abuse prevention training programs ended on September 30, 2007. However, CMS will continue to work closely and monitor the pilot

States during the phase-down period (October 2007 – May 2008), as those States submit their final program summaries, data and cost reports, and answer any questions from CMS or the evaluator. The final evaluation study, including the pilot States' findings to specific questions raised by Congress, is targeted for submission to CMS in spring 2008.

Action Plan	Date
Monitor pilot States during phase-down period.	Fall 2007/Spring 2008
Issue final national evaluation study.	Summer 2008

2. **Improving Fire Safety in Nursing Homes**—The CMS' initiatives to reduce nursing home fires focuses on four action themes:

   - Better Protection (such as improved standards),
   - Better Information and Reporting (such as improved information on the Web),
   - Better Monitoring (such as more CMS validation surveys), and
   - Better Enforcement (such as improved methods of citing deficiencies).

   CMS continues to move toward better fire protection for nursing homes. In 2007, CMS published a Notice (70 FR 64605) proposing that all long-term care facilities that do not have automatic sprinkler systems installed throughout their buildings would be required to install such systems in accordance with the technical provisions of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems, published by the National Fire Protection Association (NFPA). The proposed rule solicited public comment regarding an appropriate and feasible phase-in period for requiring that all nursing homes be fully sprinklered. The final rule is expected to be published in summer of FY 2008.

   CMS continues to collect and report information on the sprinkler status and survey results for nursing homes. This information is available on the Nursing Home Compare Web site.

   In the realm of better monitoring and enforcement: The CMS has instructed SAs to consider nursing home fires with injuries to be investigated using CMS complaint policies and procedures for the level of "immediate and serious jeopardy." CMS continues to re-prioritize both contract and in-house resources to maintain a 17-fold increase (compared with 2004) in the number of validation surveys CMS conducts to monitor the adequacy of State Life Safety Code (LSC) surveys. This level was sustained in 2006 and will continue into 2008. In addition, CMS will implement a new process that will allow Federal Oversight/Support Surveys to be used to oversee LSC surveys.

Action Plan	Date
Implement Federal Oversight Support Survey (FOSS) process for LSC surveys.	Winter 2008
Publish Final Rule-Making that would require all nursing homes (existing and new) to be fully sprinklered.	Summer 2008
Sustain increase in CMS validation surveys for LSC to promote oversight and effective implementation of LSC surveys by States.	Ongoing

3. **Interpretive Guidance to Surveyors**—The CMS continues to revise the Interpretive Guidance to Surveyors for Long Term Care Facilities for selected regulatory requirements. This updated guidance is being developed through an interactive process. The guidance will support a nationally consistent application of the survey process in evaluating facilities for compliance with nursing home requirements. The products include interpretive guidance based on current standards of practice, investigative protocols, and guidance to determine the severity of deficiencies identified in a survey.

   In addition to the guidance itself, we continue to provide improved methods by which the information is communicated and the training available to both surveyors and providers, including advance copies, training tools, and satellite broadcasts (where needed).

   In FY 2008, important new guidance will be released for the following areas:

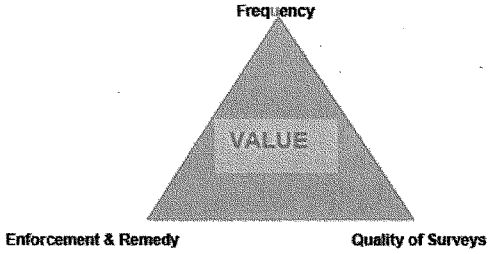
Action Plan	Date
Sanitary Conditions and Nutrition, Safe Food Handling (F325 and F371)	Summer 2008
Pain Management (as part of F309)	Fall 2008

4. **Refinement of State Performance Standards**— In FY 2001, CMS implemented uniform State performance standards for the States. In FY 2002, CMS added hospitals, end-stage renal disease (ESRD) facilities, intermediate care facilities for people with mental retardation, and home health agencies to the State performance standards. By 2005, the system had expanded to cover seven areas[2], each with its own subparts, and was at some risk of losing its understandability.

   For FY 2006, we reorganized the State Performance Standards System (SPSS) to a three-dimensional model. We made this change to emphasize the fact that the value of the survey program comes from (a) the completion of surveys, (b) the quality of the surveys themselves and proper identification of deficiencies, and (c) appropriate enforcement and remedy of identified problems, preferably through systemic change.

[2] Frequency of surveys; Accuracy of survey documentation; Results of surveys performed by Federal surveyors concurrent with State surveyors; Timeliness of processing surveys and sanctions; Budget expenditures; Prioritizing and investigating complaints; and Timely entry of data into tracking system.

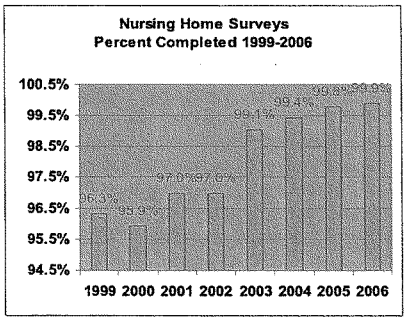
The fundamental elements in the SPSS have remained the same, with improvements made to: (1) align performance measurement with Federal survey and certification priorities, (2) assure that non-nursing home provider/suppliers are being surveyed, and (3) respond to changes made to policies and guidance.



Frequency + Quality of Surveys + Enforcement and Remedy = Value

- *Frequency:* Off-hour surveys for nursing homes, frequency of surveys, frequency of data entry of standard surveys;
- *Quality of Surveys:* Documentation of deficiencies; conduct of surveys in accordance with Federal standards; documentation of noncompliance; accuracy of documentation; prioritizing complaints and incidents; timeliness of complaints and incident investigations; quality of Emergency Medical Treatment & Labor Act (EMTALA) investigations; and quality of complaint/incident investigations;.
- *Enforcement and Remedy:* Timeliness of processing immediate jeopardy cases; timeliness of mandatory denial of payment for new admissions notification; processing of termination for non-nursing homes; and special focus facilities.

The SPSS has contributed to improved performance in key areas. The following graph, for example, shows the percentage of nursing homes for which a survey was conducted every 15 months. Performance increased from 95.9% in FY 2000 to 99.9% in FY 2006.



Action Plan	Date
FY 2008 State Performance Standards effective, with revisions.	Fall 2007
Develop national reports to support the evaluation of the State Performance Standards and to allow for continuous monitoring by the States and Regional Offices.	Ongoing
Monitor State performance and require that States develop and implement corrective action plans to address identified problems.	Ongoing

5. **Federal Comparative Validation Surveys**— Comparative surveys are surveys conducted by CMS, shortly after a State survey, in order to assess the quality of the State survey. In FY 2002, a Government Accountability Office (GAO) study recommended that CMS conduct a greater number of comparative surveys. CMS responding to this recommendation sought to increase the number of comparative surveys through a contract effort. In 2003, CMS awarded a five-year contract to recruit and train surveyors to perform Federal comparative surveys; FY 2008 will be the final year for this contract. Comparative health surveys will remain approximately the same as that for FY 2007. Health surveys will predominantly be conducted in States that historically have had survey problems; and may include facilities with high incidence of pressure ulcers, restraint use and enforcement issues. In addition, CMS will continue improvements to its database to promote improved analysis and follow-up on the findings from the validation surveys.

Action Plan	Date
Continue 200 LSC surveys and approximately 15–50 focused health surveys; and 6–9 Medicare non-LTC surveys.	Ongoing during FY08
Conduct evaluation of contractor performance, including quality, costs, citation rates, timeliness of surveys.	Ongoing until end of contract.
Continue improvements to the validation database to promote improved analysis and follow-up on the findings.	Fall 2008

6. **Improved Surveys Via the "Quality Indicator Survey (QIS)"**— The CMS has been studying methods to improve the consistency and effectiveness of the survey process pursuant to internal CMS recommendations and GAO studies. This is critically important to improve CMS' ability to gather and compare surveyor data among States. Such improved consistency also will provide better data for consumers through the Nursing Home Compare Web site and will give nursing home providers useful information on their performance. The desired improvement supports the need for a system that uses data as a decision-making tool. The purpose is to better focus surveyors on potential areas of concern. CMS is evaluating the enhanced surveyor process through the five-State demonstration conducted in FY 2006–2007. The 5 state evaluation is Phase 1 of the demonstration.

   The "QIS" is a two-stage computer assisted process. Stage 1 consists of both (a) off-site data [such as MDS] and (b) data collected on-site from two samples. The information is

used to derive a set of Quality of Care Indicators that can be compared to national norms.

Stage 2 is a systematic investigation of areas flagged in Stage 1. Many of the investigations are organized around critical elements with investigative probes for triggered care areas.

Action Plan	Date
Development of Training Model–two-state demonstration (FL,CT).	Fall 2007
Complete second part of QIS Evaluation Phase I five-state demonstration (Summative Evaluation).	Winter 2007-2008
Final report of evaluation, Phase I & Action Plan for Phase II.	Spring 2008
Conduct "Train the Trainer Program" in participating States	Fall 2007-Spring 2008
Expand Statewide implementation of QIS to 1-3 new States for a total of up to 8 States	Winter 2008-Fall 2008

7. **Establishment of Escrow Accounts for Civil Monetary Penalties**—Presently, imposed Civil Monetary Penalties (CMPs) are not due and payable until after a final administrative decision is made about the noncompliance upon which the penalty was imposed. Often, facilities do not actually pay the CMP until years after its imposition due to a statutory requirement that provides that payment of the CMP is suspended until after the appeal has been adjudicated. Delays in collecting these CMPs diminishes their deterrent effect. Based on action from Congress, CMS will develop and publish a Notice of Proposed Rulemaking to implement any new legislation.

Action Plan	Date
Develop and submit a legislative proposal to establish an escrow account whereby CMPs would be collected and put into an escrow account pending the outcome of the appealsprocess. [Note: The Federal executive branch does not introduce legislation. The only value of CMS' proposal is to signal to Congress the desirability of congressional action.]	Completed
Develop and publish a Notice of Proposed Rulemaking to implement any legislation that Congress passes.	Dependent upon new legislation.

8. **Monitor Civil Monetary Penalty Amounts**—CMS will monitor the amounts of CMPs recommended by States to insure consistency with statutory and regulatory factors such as scope and severity, repeated deficiencies, and numbers of deficiencies.

Action Plan	Date
Monitor appropriateness of tool amounts and RO's findings about consistency with State-proposed penalty amounts.	Ongoing

9. **Special Focus Facilities** – In the years 2000 to 2006, the CMS certified an average of 16,352 nursing homes each year. While many nursing homes meet minimum nursing home requirements either upon survey or within a short period afterwards, there are some nursing homes that pass one survey only to fail the next (for many of the problems as before). Our experience shows that such facilities rarely address the underlying systemic problems that have given rise to repeated cycles of serious deficiencies.

   In recognition of this phenomeon, the CMS created the Special Focus Facility (SFF) program in 1998 as one of the initiatives of the Nursing Home Oversight and Improvement Program. The purpose of the SFF program was to decrease the number of persistently poorly performing nursing homes by focusing more attention on nursing homes with a record of poor survey performance. In January 1999, CMS directed State survey agencies (SAs) to conduct two standard surveys per year for each SFF instead of the one required by law. CMS also requested that States submit a monthly status report listing any surveys, revisits, or complaint investigations of SFF they had conducted in that month.

   CMS and the States identified areas where the SFF program could be improved. In December 2004, CMS augmented the SFF program by:
   - ***More Nursing Homes:*** Increasing the total number of facilities by about 30%, with larger States doing more than smaller States (instead of 2 nursing homes in every state).
   - ***Better Selection***: Improving the data and methods by which substandard nursing homes are identified. Facilitating the ability of States to move on to other nursing homes on the candidate list if the original facilities show significant improvement.
   - ***Stronger Enforcement***: Implementing more robust enforcement for nursing homes that fail to make progress.
   - ***Reduced reporting burden***: Removing the monthly reporting requirement for States. Current requirements for surveying each SFF twice a year remain unchanged.
   - ***Building in Timeframes for Action***: Requiring that nursing homes have three standard surveys to make improvements and graduate from the program, make significant improvement or face termination.

   In FY 2008, CMS is further improving the SFF initiative. The first improvement is to require that States notify nursing homes that have been designated as a SFF. We are also requiring that States notify other accountable parties such as owners, governing parties, etc. We are further requiring that States notify additional parties such as the State Ombudsman, the State Medicaid Agency, and a State's Quality Improvement Organization.

In addition, we are posting on the CMS Web site the names of all SFF nursing home homes. The names are organized so consumers and families can distinguish between nursing homes that have significantly improved or not, have graduated, and those that have terminated participation in the Medicare, as well as SFF nursing homes that have recently been added to the SFF initiative. Finally, CMS will also "flag" nursing homes on its Nursing Home Compare Web site for those nursing homes that are part of the SFF initiative.

Action Plan	*Date*
Issue final policy with guidance on notification requirements.	Fall 2007
Post all SFF names on CMS website. (see http://www.cms.hhs.gov/CertificationandCompliance/12_NHs.asp)	Spring 2008
Add SFF designation to specific nursing homes on Nursing Home Compare.	Spring 2008

10. **Update Nursing Home Nurse Aide Training Curriculum**—CMS has contracted Abt Associates to more extensively document the problems with nurse aide training. This information is being used to assist CMS to develop specific policy and program options to improve nurse aide training. Although CMS originally anticipated completing their report in 2005, it became clear there was a need to conduct additional analyses of mechanisms that will ensure effective Federal and State oversight of whatever options might be selected for improvement. That component has been added to the report with an expected completion date of March 2008.

Action Plan	*Date*
Complete draft of Phase I report.	Fall 2007
Circulate selected chapters for experts for review.	Fall 2007
Revise draft Phase I report.	Winter 2007/2008
Complete draft of Phase II report.	Winter 2007/2008
Circulate selected chapters for experts for review.	Winter 2007/2008
Revise draft Phase I report.	Winter 2007/2008
Issue final report of Policy Options	Summer 2008

11. **Training**— In FY 2008, CMS will expand training opportunities for surveyors to better equip them. Expanded training will include:

(a) Adding a southern venue, in addition to the western venue developed last year. This targets a select number of courses to ensure improved training access for States in time zones most distant from Baltimore, Maryland. We have piloted new approaches to partnering with State agencies that allow us to better use the more sophisticated State training groups to expand our training resources. We refer to these as Magnet Area Training (MAT). Pilots in Florida and California should be completed and evaluation documented by early FY 2008. We want to complete these actions before widely offering the MAT products to other areas.

(b) Web Based Training (WBT). The "Abuse and Neglect Complaint Investigations" WBT was launched in early 2007 as well as other topics in a WBT format. These WBT formats also may be offered to providers to establish an idea of what they should expect from surveyors.
(c) Eight basic surveyor training courses in both Health Surveys and six in Life Safety Code (LSC) currently are offered. To make training more easily accessible, we created and are piloting (September 2007) what we call the Virtual Classroom version of the LSC Basic. This will allow surveyors to access training at any time of day via the internet and to still have opportunities for interaction with students and instructors. This is a live-instructor-facilitated training and goes beyond the depth and complexity of WBT available through other mediums.
(d) Specialized training on the National Fire Protection Association Standard for Gas and Vacuum Systems (NFPA 99). Two classes are offered annually on this topic.

In addition to classroom training for basic classes, satellite broadcasts and Web casts have been increased and archived by CMS for later viewing. These are on relevant clinical and program topics to increase consistency and understanding of Federal requirements among surveyors and providers. The Web casts, satellites, and related videos are available for one year after they are first presented. Subject Matter Experts extend the life of these training tools at the end of each year to assure that the materials are still current. In addition, DVDs, and CDs have been distributed to Regional Offices and major stakeholder groups. Finally, to assure a sustainable, trained workforce, a specialized contractor will review outcomes of relevant studies mentioned above to create a more robust integration of training topics that include elements of ACTS, complaint investigation, basic surveyor, and other advanced or specialized skills. The outcome of the contractor's work will produce a "life cycle" curriculum for both new and established surveyors. This life cycle curriculum is being developed incrementally in priority order, pilot tested, and launched. Then this training is linked into a sequence of training. For example, a student now takes the Basic LSC Class, followed by the FSES/Health Care and NFPA 99 trainings. Then these surveyors are considered fully qualified to survey in all areas of the LSC that apply to regulated entities.

Action Plan	Date
Add a southern venue, in addition the western venue developed last year.	Fall 2009
Launch courses on "Abuse and Neglect Complaint Investigations," as well as other topics in a WBT format.	Completed and being added as new WBT as needed
Conduct eight basic surveyor training courses in both health surveys and LSC, adding an additional LSC classes to address oversight surveys.	Completed and being maintained
Develop Life Cycle Curriculum	Fall 2009 – Summer 2010

C. Quality Improvement

We are promoting a program of quality improvement in a number of key areas. These areas include reduction in the prevalence of preventable pressure sores that threaten the health and well-being of a significant number of nursing home residents and reduction in the extent to which restraints are used in nursing homes.

1. **Government Performance and Results Act (GPRA) Goals**— The CMS has two goals specifically related to improving care in nursing homes: reduce pressure ulcers and reduce unnecessary restraints. CMS has worked diligently to address these problems. However, disparities remain in rates among regions, States, and across nursing homes. The effort now needs additional impetus, especially in those States where physical restraint and pressure ulcer rates exceed the national average, in order to reduce the national average. To assist us in our efforts, CMS has developed tables containing the current GPRA measures for each region, a target, and a stretch goal equal to the average percent reduction submitted by the QIOs. These goals will help CMS measure the success of their efforts to improve these two care issues.

    a. Reduce Pressure Ulcers—Over the last several years, CMS, SAs, and QIOs have worked with LTC facilities to improve performance with respect to pressure ulcer prevention.

        i. Regional Follow-up and Data Analysis— Although other quality measures (such as restraint use and pain management) have improved, reducing the prevalence of pressure ulcers nationally has proven to be more difficult. While pressure ulcer rates had been steadily increasing for years, CMS now has the first data to indicate that there may be a decline in the rate of some pressure ulcers. Between the third quarter of 2003 and the first quarter of 2007, the prevalence of pressure ulcers declined from 8.9 percent to 8.7 percent. Using a new quality measure for high risk pressure ulcers, over the same time period, the rate dropped from 13.8% to 12.8%, a relative improvement of about 7%. There are even more encouraging results from those nursing homes recently working closely with their QIOs. Their high risk pressure ulcer measure decreased from 13.4% in the second quarter of 2004 to 11.9% in the first quarter of 2007—a relative improvement of 11%.

        In 2008, CMS will redesign the QIO program while continuing to improve quality of care and services in nursing homes.

        ii. QIO Initiatives with Nursing Homes: In 2007 and 2008, every QIO was charged with working with nursing homes to improve the prevention and treatment of pressure ulcers. In this initiative, each QIO helps participating nursing homes set goals and develop methodologies by which those goals may be realistically reached. AHRQ is funding a real time intervention research project for preventing pressure ulcers. This project is working with QIOs in several States and helps fulfill the 8th Scope of Work goal of pressure ulcer prevention.

b. Reduce unnecessary restraints— Over the last several years, CMS, SAs, and QIOs have worked with LTC facilities to improve performance in key quality of life and quality of care issues, such as restraint use, pain management, and pressure ulcer prevention.

   i. Regional Follow-up and Data Analysis— The CMS, SAs, and QIOs are all working with nursing homes to reduce unnecessary restraints in nursing homes. There has been a consistent decrease in the prevalence of physical restraints since the beginning of the measure in the second quarter of 2002; the prevalence of physical restraint use in nursing homes was 9.3 percent in 2002, 7.8 percent in 2003, 7.2 percent in 2004, 6.6 percent in 2005, 5.9% in 2006, and 5.6% in the first quarter of 2007.

   In 2008, CMS will redesign the QIO program while continuing to improve quality of care and services in nursing homes.

   ii. QIO Initiatives with Nursing Homes: In 2007, every QIO will be charged with working with nursing homes to reduce unnecessary restraints. In this initiative each QIO helps participating nursing homes set goals and develop methodologies by which those goals may be realistically reached. In this contract cycle, there are two QIO intensive groups.

2. **Development and Validation of MDS 3.0**— The current MDS version 2.0, which is part of the Resident Assessment Instrument (RAI) and was developed in 1990 as part of the Nursing Home Reform Law of 1987 (OBRA '87), needs to be updated to more accurately reflect current standards of practice, in particular sections, and some areas may need to be simplified. Many providers feel that it is cumbersome, not useful to them as a management tool (as it is not in real-time), and does not allow for immediate analysis of a resident. This may reflect a shift in the type of residents for whom many nursing homes are now providing care. Since MDS 2.0 drives payment, publicly reported quality measures, quality indicators, the survey process, and 22 State Medicaid case-mix payment systems, modifications are required to support CMS and State activities. CMS has a memorandum of understanding with the Department of Veterans Affairs to assist with the development and testing of validation protocols for MDS 3.0. CMS also has contracted with RAND to develop and validate the MDS 3.0 and ensure that new and existing MDS items are reliable.

   RAND will complete its MDS 3.0 validation study in spring 2008 and there will be a second town hall meeting to discuss any changes with the providers, States, clinicians, etc. As noted in this report, CMS is also initiating a Post Acute Care Payment (PAC) Reform Demonstration utilizing the Continuity Assessment and Record Evaluation (CARE) tool to be used at hospital discharge and across PAC settings including nursing homes in early 2008 and a Staff Time Resource Intensity Verification (STRIVE) to enhance the accuracy and efficiency of nursing home reimbursement systems including recalibrating the resource utilization group III (RUGs III) grouper. CMS staff and its contractors are working closely to coordinate activities on these projects with other CMS initiatives.

Action Plan	Date
Complete the Department of Veterans Affairs MDS 3.0 Validation Protocol Research of New MDS items.	Completed
Conduct National MDS Validation.	Completed
Complete MDS National Validation.	Completed
Complete MDS National Validation Analysis.	Fall 2007
Hold Town Hall Meeting with nursing home stakeholders.	Spring 2008
Issue Final Validation Report.	Summer 2008

3. **Data Assessment and Verification Contract (DAVE) 2: MDS 2.0**— CMS awarded a contract in September 2005 to Abt Associates to implement DAVE 2. DAVE 2 is the second phase of an effort begun in December 2004 to assess and verify the accuracy of data nursing homes' collect through the Minimum Data Set (MDS), and to provide tools for improving MDS coding accuracy.

   The MDS is a core set of screening, clinical and functional status items that forms the foundation of the federally mandated, comprehensive assessment administered to all patients and residents of nursing homes (NH) certified to participate in the Medicare and/or Medicaid program.

   Accuracy with coding MDS items, and verification of supporting clinical information, are essential since many of these items trigger care planning activities, drive publicly reported quality measures and quality indicators used in the NH survey/certification process and generate payment groupers for Medicare's prospective payment system, and for some States' Medicaid payment systems.

   DAVE 2 activities are slated to end on September 30, 2007. Activities drawing to a close include: focused on-site NH reviews of MDS data accuracy and reliability, development of targeting protocols and development of training and educational materials to help NHs improve coding accuracy. Coding Tip sheets developed this past year have been posted on the Web. Additional Tip sheets are in progress and will be posted before the end of 2007. Other DAVE 2 tasks for 2007 include: development and testing of targeting protocols to identify facilities at high risk for MDS coding errors, development and testing a NH self-audit process, and exploration of options for Federal/State partnerships to monitor and improve MDS accuracy.

   Starting October 1, 2007, Abt Associates will be retained under a contract designated, "MDS Technical Support" to manage CMS' electronic mailbox for MDS Questions and Answers, manage updates and revisions to the RAI Users Manual for the MDS Version 2.0, implement small-scale validation testing of targeting protocols, continue work on the two Special Studies involving the development and testing of Federal-State MDS accuracy partnership, and for development and testing of a provider self-audit tool and process.

Action Plan	Date
Continue on-site MDS reviews at nursing homes. Analyze data, produce discrepancy reports, recommendations, and educational products to improve MDS accuracy.	DAVE 2 effort to end on September 30, 2007
Manage CMS' electronic mailbox for MDS Questions and Answers. Manage updates and revisions to the RAI Users Manual for the MDS Version 2.0. Implement small-scale validation testing of targeting protocols. Continue work on the two Special Studies involving the development and testing of Federal-State MDS accuracy partnership, and development and testing of a provider self-audit tool and process.	"MDS Technical Support" to start October 1, 2007

4. **STRIVE National Nursing Home Time Study**—CMS reimburses Medicare Part A skilled nursing services on a prospective payment system (PPS), which uses the Resource Utilization Group, version 3 (RUG-III), classification system to determine payments based on resident data. This skilled nursing facility PPS was introduced in 1998, and was constructed on the basis of staff time measurement studies conducted in 1990, 1995, and 1997.

   CMS awarded a contract in September 2005 for a national study called STRIVE (Staff Time and Resource Intensity Verification) to examine how nursing homes allocate their staff time and resources. CMS worked actively with State Medicaid Agencies and nursing home associations to make this study a comprehensive examination of both post-acute and long-term care populations. STRIVE completed its on-site studies of 15 States in August 2007: District of Columbia, Florida, Illinois, Iowa, Kentucky, Louisiana, Michigan, Montana, Nevada, New York, Ohio, South Dakota, Texas, Virginia, and Washington. About 200 nursing homes from a randomly selected sample volunteered to participate.

   STRIVE has now turned to analysis of the data collected, which reflects the most recent care practices and resource needs of nursing homes. This data will be used to update Medicare's RUG-III case mix structure and payment rates. Since almost half the states in the country use a version of the RUG-III system to determine payment rates for their Medicaid nursing homes, the national data will be made available to State Medicaid agencies to evaluate their payment structures.

   As the lead component for this study, the Center for Medicare Management (CMM) has benefited from the collaborative approach encouraged through the Long Term Care Task Force and has incorporated aspects of other CMS initiatives into the study design. For example, CMM is working with the Office of Clinical Standards and Quality (OCSQ) to

test both potential MDS 3.0 items, including a new depression item, and new pain and pressure ulcer items for use in quality measurement. CMM and OCSQ have been in contact almost weekly coordinating efforts regarding the MDS 3.0 project and STRIVE. STRIVE will continue to share information on the items studied, including inter-rater reliability analysis of the pain and pressure ulcer items. CMM also is partnering with the Center for Medicaid and State Operations (CMSO) to test new MDS discharge potential items in support of the Money Follows the Person Demonstration. These items may be useful to identify residents suitable for community placement. Items tested for CMSO, for example, directly ask residents whether they: want to learn about options for living in the community, have available places to live, and prefer to live in the community. STRIVE continues to provide CMSO with feedback regarding the items. STRIVE also asked participating facilities to voluntarily complete a survey, "Artifacts of Culture Change," developed by CMSO and a contractor. This survey captures information about changes to traditional nursing home staffing and work environment--information which may help future analytic efforts.

CMS believes the study results will reflect current practices and update the existing nursing home payment system while using that system to promote high quality care.

Action Plan	Date
Publish Notice of Proposed Rulemaking for SNF PPS.	Spring 2008
Issue Final Rule for SNF PPS.	Summer 2008

5. **Study of State Feeding Assistant Programs**—In September 2003, CMS published a final rule, "Requirements for Paid Feeding Assistants in Long Term Care Facilities" (68 CFR, 55527), that allows long-term care facilities the option to use paid feeding assistants, if consistent with State law. This rule was published in response to the recognition of the adverse affects that a shortage of nurse aide staff can have on assisting nursing homes residents with eating, the difficulties providers face with recruiting and retaining nurse aide staff, and, subsequently, the absence of a provision in the regulations that would allow for the use of single-task workers, such as paid feeding assistants. The final rule permits a long-term care facility to use paid feeding assistants to supplement the services of certified nurse aides under certain conditions. States must approve training programs for feeding assistants, using Federal requirements as minimum standards. Feeding assistants must successfully complete a State-approved training program and work under the supervision of a registered nurse or licensed practical nurse. The intent is to provide more residents with help in eating and drinking and reduce the incidence of unplanned weight loss and dehydration.

   While a few States had extensive experience with such feeding assistants without any indications of adverse consequences, it is important that CMS track and analyze the results when more States are involved. Both CMS and the Agency for Healthcare Research and Quality (AHRQ) wished to be attentive to the concerns about potential problems expressed when it was promulgated. In 2004, through a joint effort, CMS and AHRQ awarded a two-phase contract to Abt Associates to study feeding assistant

programs. In order to gain a sound understanding of the implementation of paid feeding assistant programs among the States, the first phase requires using a descriptive study design to gather information about a wide array of characteristics of feeding assistant programs. Phase I started in October 2004 and was completed in September 2006.

Phase II of the contract started in September 2006. The purpose of this study is to design, implement, and evaluate an optimal feeding assistant program, one that is not only consistent with Federal requirements for paid feeding assistant training, but that provides more hands-on guidance for both supervisory and feeding assistant staff about how to enhance the quality of both the dining experience and the nutritional intake of the nursing home resident. The final deliverable from this contract will include a training manual that providers can use to help implement paid feeding assistant programs. This will be completed by the end of September 2008.

Action Plan	Date
Completion of Phase II of project.	Fall 2008
Completion of project report and training manual.	Fall 2008

6. **Working with Quality Improvement Organizations**— QIOs are Medicare contractors located in every State and territory that provide free assistance on a voluntary basis to nursing homes to address issues related to quality of care.

   Between August 2002 and July 2005, QIOs worked with nursing homes, focusing primarily on the areas of pain, physical restraints, and pressure ulcers, through the provision of assistance to help them make changes to care processes. Facilities working intensively with a QIO showed significant improvement. Those homes that worked closely with a QIO were very successful in reducing their rates of pain and use of physical restraints. Homes working with a QIO did not see a significant decrease in their rate of pressure ulcers. However, the rate of pressure ulcers in these homes did not increase as it did in the rest of the Nation's nursing homes, from 2002 to 2005[3].

   The QIOs operate under three-year contracts. Under the QIO's 8th contract (which began in August 2005, and extends to August 2008) QIOs will continue to (a) provide assistance on care process changes, (b) working with nursing homes to set quality improvement targets, (c) helping nursing homes to track whether they are effectively implementing changes in processes of care, and (d) providing assistance to help nursing homes make organizational changes that focus on the needs of residents and decreasing staff turnover. These organizational changes have been shown to have a positive effect on clinical measures.

[3] Rollow W, Lied T, McGann P, et al. "Assessment of the Medicare Quality Improvement Organization Program." Annals of Internal Medicine, 2006:145(5):342-353. 5 September 2006.

The QIOs are providing intensive assistance to approximately 2,400 nursing homes, with the following aims:

- Reduce pressure ulcers
- Reduce the use of physical restraints
- Reduce the prevalence of pain
- Improve detection and management of depression
- Increase a focus on person-centered care, and improve nursing staff retention

To accomplish this, QIOs help participating nursing homes make changes to clinical care processes, and move away from an institutionalized care model and toward a more person-directed care model that is individualized to meet the needs of each resident. As part of this work, QIOs are helping these nursing homes to monitor their levels of staff turnover and to help them implement an annual survey of resident satisfaction as well as an annual survey of staff satisfaction. QIOs then help nursing homes use the feedback from these surveys to redesign processes to better meet the needs of residents and staff, resulting in a more efficient and effective environment.

Action Plan	Date
9th Scope of Work Re-design.	August 2008

7. **Expansion of Collaborative Focus Facility (CFF) Project**— Between August 2004 and August 2005, a subset of Quality Improvement Organizations (QIOs) worked closely with their State agencies (SA) to identify homes that might benefit from some intensive assistance from the QIOs in redesigning their approach to clinical care. Some of these homes included Special Focus Facilities, while other homes were recommended because of a history of repeat survey deficiencies. After 12 months of intensive assistance, 42 nursing homes across 18 States illustrated the success of this demonstration in improving clinical quality and reducing the number of serious survey deficiencies. As of November 2005, nursing homes that participated in this project showed dramatic improvement as a result of the effective collaboration between SAs and QIOs.

   - High-risk pressure ulcers decreased by 18 percent [compared with no improvement nationwide during this same time period].
   - Low-risk pressure ulcers decreased by 49 percent among the CFF nursing homes [compared with no improvement nationwide].
   - Nursing homes referred by SAs that participated in this pilot reduced their use of daily physical restraints by 37 percent compared to an 8 percent nationwide reduction in the use of daily physical restraints.
   - Total number of deficiencies decreased by 11 percent among participating homes while deficiencies cited as level G (potential for serious harm) or worse, decreased by 26 percent.

The involved nursing homes had been cited repeatedly for serious deficiencies and had not improved in the past. The CFF project indicates that collaboration of both SAs and QIOs to work with low performing homes can improve the quality of care provided in these homes.

As a result of these successes, this project has been expanded into a mandated portion of the QIO 8th Scope of Work. Under the new contract, QIOs working in partnership with their SAs have identified homes that have shown persistent survey deficiencies and might benefit from QIO assistance. QIOs are now assisting them to decrease their rates of pressure ulcers and use of physical restraints while redesigning their organizational structure to better meet the needs of residents and staff.

Action Plan	Date
Teaching nursing homes how to track their own clinical care processes.	Ongoing
End of contract and final evaluation.	Spring 2008

8. **Culture Change**— The CMS began its efforts to improve the quality of care and quality of life in nursing homes with the passage of the Health Care Financing Administration's (HCFA, now CMS) regulations that implemented the OBRA '87 law's mandates for quality of life, quality of care, and resident rights. To further the Agency's work to implement these important aspects of the law and regulations, the Agency has become a part of a national movement known as "culture change." (Other terms include "resident-directed care," "person-centered care," and "individualized care.") Culture change principles echo OBRA principles of knowing and respecting each nursing home resident in order to provide individualized care that best enhances each person's quality of life. The OBRA regulations are not, as is commonly perceived, a barrier to culture change, but in fact support it as an optimum implementation of the law that mandates resident dignity, autonomy, and quality of life. The concept of culture change encourages facilities to change outdated practices to allow residents more input into their own care and encourages staff to serve as a team that responds to what each person wants and needs.

   The CMS has participated in several initiatives and projects to assist facilities in incorporating the concept of culture change. This includes surveyor training in a 2002 satellite broadcast that introduced culture change principles to the surveyors; a joint project with Quality Improvement Organizations (QIO) to teach nursing homes in every State about these principles; providing regulatory answers to facilities that want to institute the concept of culture change; collaboration with QIOs in their national culture change Scope of Work; the 2006 release of a report of culture change outcomes and a new questionnaire tool to assist nursing homes to evaluate their degree of culture change (Artifacts of Culture Change, located at http://siq.air.org), and a series of satellite broadcasts in FY2007 on various aspects of culture change.

   In FY 2008 CMS is sponsoring a public symposium in Washington, DC titled *Creating Home in the Nursing Home: A National Symposium on Culture Change and the Environment Requirements*. The symposium will gather experts and stakeholders to discuss

issues of changes to the environment that may be impacted by Federal and State regulations and the Life Safety Code. A public one-day symposium will be followed by an invitational workshop to permit further discussion of issues and do action planning with experts, stakeholder groups, CMS, AHFSA, and the National Fire Protection Association.

CMS also will participate on and advisory committees for a culture change project with the Rhode Island survey agency titled: Promoting Individualized Care: The Regulatory Imperative. The project is testing enhancements to the survey and enforcement processes to promote individualized care in accord with federal quality of life requirements.

In addition, the agency will participate in a Veterans Administration (VA) culture change steering committee. The VA is in the beginning stages of applying the principles of culture change to all their nursing home care units. CMS also will participate in an advisory capacity with stakeholder organizations that are working toward the automation of the CMS Artifacts of Culture Change tool into a publicly available online data base in which a home can compare its level of culture change accomplishments to peer homes in its State and nationally.

To further CMS' work in fostering individualized and resident-directed care, CMS plans the following action items

Action Plan	Date
Convene a Symposium/Work Shop on Culture Change and the Environment.	Spring 2008
Participate on advisory committees for culture change project on Promoting Individualized Care.	Ongoing through FY '08
Participate on Veterans Administration culture change steering committee.	Ongoing throughout FY '08

D. Quality Approaches Through Partnerships

Effective assurance of quality in nursing homes can only be achieved through the combined, motivated, and, preferably, coordinated action of many actors in the health care system, including:

- Consumers, their families, and their friends;
- Providers;
- Purchasers, including CMS, States, and private and public health care plans, and individual purchasers or policy-holders;
- Professionals, professional associations, workers of all types;
- Survey and Certification agencies (States and CMS);
- Quality improvement organizations;
- Universities and other educational organizations;
- Legal rights organizations, including advocacy organizations such as the AARP, State Ombudsmen, and law enforcement.

Each individual in the system has a different role and set of responsibilities. However, the goal of quality care is advanced when more and more principals in the system can act in concert toward common objectives. When such concerted action is achieved, the total can indeed become greater than "the sum of its parts." CMS seeks to expand the level of collaboration among the principals who have responsibility for ensuring quality.

1. **Quarterly Meetings with States**— The CMS will continue to meet with the Association of Health Facility Survey Agencies (the national organization representing SAs) four times a year, three of which are in person. CMS also works with States on new policies and procedures, frequently seeking their review and comment on relevant topics.

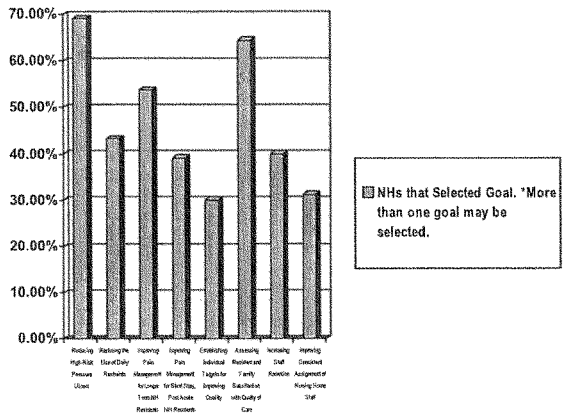
2. **Leadership Summit**— The CMS will sponsor the fifth annual joint meeting with SAs in April 2008 in the Baltimore area, to build better communication and strengthen understanding of program initiatives. Although the agenda covers all providers and suppliers in the survey and certification program, nursing homes will be a strong emphasis.

3. **Communicating with Other Stakeholders**— The CMS presents annually at national training conferences for several national associations such as the American Health Care Association and the American Association of Homes and Services for the Aging, as well as interim meetings with the regulatory subcommittee and the legislative training session held in Washington, D.C., each year. We also hold stakeholder meetings periodically on various topics of interest. CMS also meets with consumer advocates such as the National Citizens Coalition for Nursing Home Reform and the AARP for purposes of exchanging information.

4. **Advancing Excellence in America's Nursing Homes Campaign**— CMS is collaborating with more than 20 national organizations to facilitate a national nursing home quality campaign entitled *Advancing Excellence in America's Nursing Homes*. The unprecedented, collaborative campaign seeks to dramatically advance the quality of care and quality of life for those living or recuperating in America's 16,000 nursing homes. The *Advancing Excellence in America's Nursing Homes* Campaign is helping nursing homes and others coordinate their energy and resources to build upon various current initiatives such as Quality First, CMS' Nursing Home Quality Initiative, the Campaign for Quality Care, and the culture change movement.

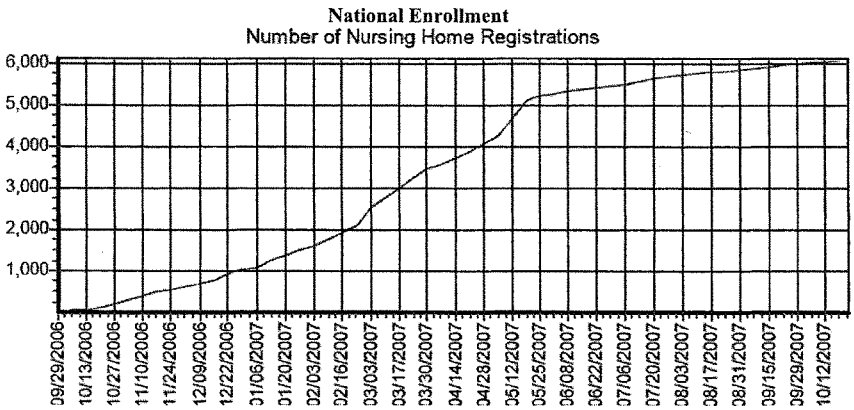
   The national campaign is focused on the following measurable goals:
   - Reduction in high risk pressure ulcers
   - Reduction in the use of daily physical restraints
   - Improvement in pain management in long stay residents
   - Improvement in pain management in short stay (post acute) residents
   - Setting individualized quality improvement targets
   - Regularly assessing resident and/or family satisfaction and incorporating this information in their quality improvement activities
   - Regularly measuring staff turnover and working to reduce turnover rates
   - Adoption of consistent assignment whereby residents are regularly cared for by the same caregiver.

Selection of Campaign Goals by Nursing Homes
March 1, 2008



The Campaign was launched at a National Nursing Home Quality Summit meeting in Washington, DC on September 29, 2006. As of May 2007, more than 5,000 facilities had joined the Campaign, committing to work on at least three of the campaign's eight measurable goals to improve their quality of care. In addition, more than 1,100 consumers have joined the Campaign. Participating consumers are promoting the Campaign by:

- Encouraging nursing homes to sign onto the campaign; and
- Asking nursing home administrators if they are participating and which goals they have chosen.



The campaign will continue for two years with participation of providers, consumers, and supporting organizations. Progress toward the goals will be posted on the campaign's Web site at: www.nhqualitycampaign.org.

5. **Medicare Quality Improvement Community (MedQIC)**— Created and sponsored by CMS, MedQIC (www.medqic.org) is a free online resource that supports quality improvement work by nursing home providers, and their respective State QIO, working on the priority topics of Medicare's QIO Program. MedQIC enables QIOs and providers to acquire and disseminate information that supports the four key strategies for the National QIO Program Priorities: (1) measure and report performance, (2) adopt health information technology, (3) redesign care process, and (4) transform organizational culture. These strategies are catalysts of organizational change for improving clinical care processes and support movement away from an institutionalized care model toward more person-directed care.

   MedQIC resources supporting these strategies include QIO/QIOSC-developed assessment and data collection tools like the Nursing Home Improvement Feedback Tool (NHIFT), and the Setting Targets - Achieving Results (STAR) Web site, to evidence-based clinical practice recommendations by leading academic organizations, research and guidance by professional quality improvement organizations, and consumer advocacy groups at the forefront of healthcare transformation.

   Other resources found on MedQIC support broad administrative goals regarding leadership, reducing workforce turnover, and improving staff satisfaction. QIOSC staff adds new content daily to MedQIC to support the quality measures defined by CMS in the 8th Scope of Work. Specifically, QIOs and providers will find a significant amount of content focused on: (1) reduction of pressure ulcers, (2) reduction of physical restraints use, (3) reduction of the prevalence of pain, (4) improvement of detection and management of depression, (5) increase in immunizations rate, and (6) offering of person-centered care.

Recent improvements to the site include practice setting tabs across the top with topics easily displayed when the setting tab is clicked, enhanced search results, a features box with the most prominent topics and tools, and improved literature categories with article publication dates. Future enhancements are listed below:

Action Plan	Date
Conduct MedQIC redesign.	Summer 2008

6. **Emergency Preparedness in Nursing Homes**— Hurricanes Katrina and Rita highlighted the need for a more effective and comprehensive emergency preparedness plan that will prepare nursing homes for incidents that range in severity from local isolated disasters to a total system collapse, as witnessed in New Orleans. The CMS has been working and collaborating with the State agencies (SA), and other emergency partners to develop an integrated and coordinated process to ensure continuity of essential survey and certification (S&C) functions, data capability and protection, and an effective emergency response in the face of any potential disruptive event (e.g., hurricane, tornado, earthquake, fire, chemical spill, nuclear or biological attack, pandemic, etc.). CMS is working closely with other HHS operating divisions and the Department of Homeland Security, to develop updated plans to ensure local, State, interstate, regional, and tribal entities are able to effectively respond to populations that are at risk. CMS plans to improve the survey and certification emergency planning process through the following activities:

   a. Establish emergency preparedness requirements for SAs regarding communication, system capabilities for tracking provider status, maintaining data reports during disruptive events, and essential business functions.
   b. Continue working with the Survey and Certification Emergency Preparedness Stakeholder Communication Forum, to ensure effective and updated guidance, recommendations, and tools are maintained to assist SA and health care provider emergency planning efforts, as well as provide clear direction regarding the roles, responsibilities and actions of the S&C Central/Regional Offices and SAs.
   c. Update the *State Operations Manual* to provide thorough and effective guidance regarding current health care provider emergency preparedness requirements.
   d. Analyze current health care provider emergency planning regulations, standards and policies, and develop consistent and robust provider requirements and policies that ensure the health and safety of patients and residents in nursing home and other health care settings (including home and community-based settings).
   e. Maintain a user-friendly S&C Emergency Preparedness Web site that will help to disseminate information, resources, checklists and other tools to SAs and providers.

Action Plan	Date
Maintain the S&C Emergency Preparedness Web site, including SA and provider promising practices, resources, and other tools.	Ongoing
Maintain regular communication with Emergency Preparedness Stakeholder group, to collaborate and dialogue on improvements to health care emergency planning and response. (See http://www.cms.hhs.gov/Emergency for CMS Website).	Ongoing
Issue updated and improved emergency preparedness interpretative guidance.	Fall 2008
Developing Notice of Proposed Rulemaking that would go across all provider types.	Summer 2008

7. **Long-Term Care Task Force**— In 2005, CMS formed an internal LTC Task Force. The principal goal of the group is to have a full alignment of all different aspects of LTC, from payment, to technical assistance, to oversight. The task force has representation from the Center for Medicaid and State Operations, the Office of Clinical Standards and Quality, the Center for Medicare Management, the Center for Beneficiary Choices, the Office of Research, Development, and Information, and from CMS ROs.

   Although the task force is engaged around the general issues of alignment and developing improved coordination, the members also develop and promote solutions in key areas with need for advancement. Initially, these areas have included prevention and ensuring treatment of pressure sores, staffing issues and their correlation with quality outcomes, reduction in the use of restraints, development of the Nursing Home Action Plan, and creation of the Value-Based Purchasing Demonstration.

8. **Long-Term Care Rebalancing** — CMS has awarded a total of $1.4 billion, in competitive grants to States, over five years to help shift Medicaid from its historical emphasis on institutional long-term care services to a system that offers more choices for seniors and persons with disabilities from all age groups, including home and community-based services. This *Money Follows the Person* (MFP) "rebalancing" initiative was included in the Deficit Reduction Act of 2005 (DRA). Demonstration grants were awarded to 31 States in January and May of 2007 and the demonstrations will continue through September 30, 2011.

   Specifically, the demonstration will support State efforts to:
   - Rebalance their long-term care support system so that individuals have a choice of where they live and receive services.
   - Transition individuals from institutions who want to live in the community.
   - Promote a strategic approach to develop and implement a quality management strategy that ensures the provision of, and improvement of such services in both home and community-based settings and institutions. The strategy must ensure the health and safety of demonstration participants before, during, and after transition to the community, as well as ensure health and safety and those remaining in the institution.

Included in the MFP Demonstration project was the directive by Congress that CMS provide technical assistance and oversight to the MFP demonstration States, for the purpose of improving State quality management systems under Medicaid HCBS waivers. These funds will be available throughout the duration of the demonstration and CMS awarded a contract in August for the provision of technical assistance.

The MFP demonstration also includes a requirement that States demonstrate, in their applications, a thorough plan of engagement of institutional providers to maximize the effectiveness of the demonstration. Successfully rebalancing a State's long-term care system to favor home and community-based services cannot be achieved without the engagement of the institutional providers in the State.

Lastly, as part of the work discussed in item C.2., Development and Validation of MDS 3.0, CMS currently is exploring whether refinements to the MDS may assist States in achieving their rebalancing goals.

E. Value-Based Purchasing

The CMS has various initiatives to encourage improved quality of care for Medicare beneficiaries. Among these is the Nursing Home Value-Based Purchasing Demonstration (NHVBP). Under this initiative, payment would be more sensitive to differences in quality. Payment would be structured to provide better assurance that investments in improving quality will be recognized financially.

1. **Design Nursing Home Value-Based Purchasing Demonstration**— As the largest purchaser of nursing home services (about $64 billion per year), States and CMS can exert leverage to insist on high levels of quality. The NHVBD is intended to augment and reinforce other quality efforts by ensuring that financial investments made by nursing homes to improve quality will be met by payment methods that can discern the difference between excellent, good, mediocre, and poor quality.

   Under this initiative, CMS will assess the performance of nursing homes based on selected measures of quality of care. The categories (or domains) for the potential measures include staffing, appropriate hospitalizations, resident outcomes, and survey deficiencies. The demonstration will include all Medicare-eligible beneficiaries residing in nursing homes (i.e., those receiving Part A benefits as well as those that receive only Part B benefits). We expect that improvements in quality may result in avoidance of some hospitalizations, producing savings to Medicare. These savings will be shared with nursing homes that either improve quality or maintain high quality of care.

   We will conduct the demonstration in four or five States. We expect to select the host States in the winter of 2008. Then we will solicit for volunteer nursing homes within the host States. We anticipate that the participating nursing homes will be selected by the summer of 2008. After we obtain waiver approval from the Office of Management and Budget, we expect to begin the three-year demonstration in the fall of 2008.

Action Plan	Date
Select States to host the demonstration.	Spring 2008
Solicit and select participating nursing homes.	Summer 2008
Begin demonstration.	Winter 2009

2. **Post-Acute Care Instrument Development & Demonstration**—Under Section 5008 of the Deficit Reduction Act (DRA) of 2005, CMS is required to implement a demonstration to support post-acute care payment reform and to develop a single comprehensive patient assessment instrument, predictive of outcomes and resource use, for use in this demonstration. A report is due to Congress in 2011.

   CMS has contracted to develop this instrument now referred to as CARE (Continuity Assessment Record & Evaluation). During the demonstration, CARE will be administered to Medicare fee-for-service beneficiaries at hospital discharge and upon admission and discharge from Post-Acute Care (PAC) settings, which will include skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

   CARE will be an internet-based tool consisting of a common set of assessment items organized under domains of medical, functional, cognitive, social/environmental, and continuity of care. Results from pilot tests of CARE in nine Chicago provider sites, from April through July 2007, have been very positive. The Office of Information Services currently is developing the applications and IT support system for the internet version of CARE for the demonstration starting in January 2008.

   CMS expects CARE to be implemented beyond the demonstration, potentially starting with the 9th scope of work slated to begin in 2008.

Action Plan	Date
Develop, pilot test CARE.	Summer 2007
Publish Federal Register Notice and solicit public comments.	Fall 2007
Obtain OMB clearance.	Winter 2008
Conduct User Acceptance Testing. Conduct CARE and internet training. Provide help desk support.	Winter 2008
Potential implementation of CARE beyond PAC-demonstration.	Spring 2008 and onward

courant.com/news/custom/topnews/hc-haven1.artnov18,0,1229473.story

Courant.com

A COURANT SPECIAL REPORT: First Of Three Parts

No Haven For The Elderly

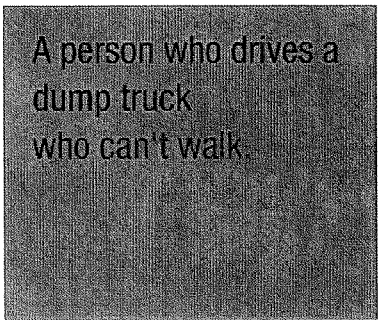
Nursing Home Troubles Show Flaws In State Oversight

By LISA CHEDEKEL And LYNNE TUOHY

Courant Staff Writers

November 18, 2007

Carrie Tondalo wasn't a complainer.



Confined to her bed in the Haven Health-Soundview nursing home in West Haven, wasting away from a lack of food and water, she urged her worried daughter, Charlotte Ciccarelli, not to complain to the nursing home staff.

"She was so parched all the time, she would drink a gallon of water when we came in to visit," Ciccarelli said of her mother,an Italian immigrant from North Haven who had worked into her 70s for garment and awning businesses. "But she didn't like us making a fuss. She never wanted to hurt anybody's feelings."

In state Department of Public Health records, Tondalo's demise is starkly recorded: She suffered from bedsores and malnutrition while at the West Haven home in 2003, and was hospitalized in May for dehydration and a urinary tract infection. The nursing home repeatedly neglected to monitor her fluid intake, weight and skin sores in the months leading up to Aug. 19, when she was rushed to the hospital again, with a diagnosis of dehydration and a documented weight of 95 pounds — a 28-pound loss from February. She died a few days later.

In late 2003, state public health officials punished the home for numerous patient-care violations, issuing a detailed "plan of correction" that directed the home to improve its procedures related to weight loss, fluid intake and infection control. The home paid a $1,270 state fine and a $12,600 federal penalty for the violations.

But in the four years since, Haven Health-Soundview has been fined by state and federal health officials six more times for a litany of patient-care violations, including neglecting bedsores and ignoring patients' care plans. The most recent citation, in May of this year, included an incident in which a nurse's aide left a sandwich within reach of an elderly woman with swallowing problems, whose care plan specified that she not be given access to solid foods.

The woman choked to death.

The home paid another fine.

It was a predictable cycle.

A Courant review of state and federal records shows that Haven Healthcare, which owns 15 nursing homes in Connecticut and 10 in other New England states, has been fined more than 45 times in the last three years for serious patient-care deficiencies — at least 30 times by the state health department and 15 by the federal Centers for Medicare & Medicaid Services, which imposes penalties for gross violations.

Many of the health violations, such as allowing residents to develop bedsores and become dehydrated, show up year after year in inspection reports, even after state and federal health officials have levied fines for those deficiencies. But the chain — one of the three largest in the state — has escaped more serious sanctions, such as a loss of government funding or operating restrictions, even in cases where the lapses in care led to patients' deaths.

Haven Healthcare's troubled record affords a window into a state and federal regulatory system that is reluctant to pull funding or licenses from nursing homes or to prosecute cases of neglect. A study earlier this year by congressional investigators found that federal overseers imposed only minimal penalties on nursing homes that were repeatedly cited for patient-care deficiencies.

Although the other large chains also have been cited for serious violations, Haven Healthcare stands out because it has faced the heaviest state fines, litigation and debt claims in the last three years, and runs a home with the highest number of patient-care violations, according to records.

But most of the state penalties imposed on Haven have been below $1,000 — significantly less than the amounts allowed by statute — with no requirements that the chain make long-term improvements in care. And even in cases where the state has used its arsenal, the impact has been short-lived.

The chain's latest inspection results offer striking evidence of the ineffectiveness of Connecticut's enforcement efforts.

The most recent federal data show that in the last 15 months, 10 of Haven's 15 homes in Connecticut have been cited for a total of 23 patient-care deficiencies ranked in the most serious categories — violations that cause harm to residents or that pose an immediate jeopardy to residents' health and safety. Nationally, fewer than one in five homes are cited for such serious deficiencies.

Ten of Haven's homes have a higher number of patient-care deficiencies than either the state or national average, with the chain's home in Waterford cited for 44 violations — the highest in the state, according to the most recent data. The three Haven homes that have been subject to stringent "consent orders" from the health department in the last three years all have cycled back out of compliance, repeating the same or similar violations.

In addition, the most recent federal surveys show that nursing staff levels in at least 13 of Haven's 15 homes fall below both the state and national staffing averages. But in a state where minimum-staffing rules have not been updated in more than 25 years, the chain has rarely been penalized for understaffing or directed to increase staff levels.

The federal inspection figures are months old, in some cases, and may not reflect current conditions.

Haven Healthcare, also known as Haven Eldercare, has been targeted since 2004 in at least seven lawsuits filed by families, including Tondalo's, who claim their loved ones died or were seriously injured in Haven homes because of negligent care. Earlier this year, Haven settled two of those lawsuits for a total of $783,000, and a third for an undisclosed amount.

The families who have filed suit worry that more patients will suffer if the chain's problems go unchecked.

"It was not a haven. It was hell," said Susana Aceituno of White Plains, N.Y., who is suing Haven's former home in Greenwich for neglecting to supervise her husband, Oscar, 78, who was paralyzed after wandering away from the home in May 2004 and falling down an embankment. "They destroyed my life. They destroyed his life completely."

Deeper Problems

Haven's patient-care problems also point to larger issues of state oversight.

In the last three years, the chain has spiraled into debt, with creditors seeking more than $20 million in unpaid bills for medication, oxygen and other supplies. But despite repeated signs that the chain's financial management could be hurting patient care, the state health and social services departments have been reluctant to intervene.

Last year, health officials learned that Haven's nursing home in Jewett City had run out of heating oil one night in December 2005, leaving residents to huddle in blankets, after the oil company suspended deliveries because of the company's repeated delinquencies, according to records.

In January 2006, Connecticut Light & Power warned the state that it was cutting off electric service to six Haven homes, after a yearlong effort to get the chain to pay its overdue bills. Haven paid the debt, reassuring state managers that it had no other financial issues "related to vendors, mortgages [or] utilities," according to notes from a February meeting.

But the Middletown company's financial issues have filled court dockets around the state. At least 12 creditors have sued Haven Healthcare since 2005. Officials in Maine, where Haven owned a home until 2005, say the company owes that state at least $1.5 million.

Records show the chain has collected millions in Medicare reimbursements for pharmaceutical supplies, but has not used that money to pay its pharmacy bills. Meanwhile, company CEO Raymond Termini used assets of Haven Eldercare, the chain's corporate parent, to buy a lakefront house in Middlefield in 2003 and to launch a record company in Nashville in late 2005. His Category 5 Records, housed in a $2.1 million building Termini purchased last December, boasts two-time Grammy winner Travis Tritt.

Last week, state Department of Social Services officials said they had begun examining Haven's finances in recent months "to determine whether the company's financial condition constitutes an emergency situation that warrants the appointment of a receiver to safeguard resident health and safety."

Attorney General Richard Blumenthal said his office also was involved in what he described as a "far-reaching investigation into possible fraud, including Medicaid and Medicare fraud," in conjunction with federal officials. He said one aspect of the investigation was whether Haven's "other financial enterprises could have siphoned away [government] funds from patient care."

In interviews last week, Termini and Haven's chief financial officer Michael Lipnicki insisted that no Medicaid or Medicare funds had been misused, and they blamed the company's financial troubles on the state's "inadequate" Medicaid funding. Termini denied that the company's financial issues had ever affected patient care, saying they were the result of bad hiring choices in some facilities.

Termini acknowledged that he had used assets from Haven Eldercare to finance the record company and buy a house on Lake Beseck, but said he had done nothing improper. He said the money for Category 5 came from refinancing Haven homes in other New England states, which he decided to invest in "non-health care companies," in the hopes they would someday generate a return to the nursing-home chain. He said he purchased the Nashville building with his own money.

Termini's management of Haven's funds has stirred a legal fight from his longtime partner, the Rev. Edward Doherty, who filed documents this month in Superior Court in Middletown, alleging that Termini and another partner improperly diverted Haven Eldercare's assets to the record label, the lakefront home and a food-service business. Doherty, who founded the Roncalli chain of nursing homes that grew into Haven Healthcare, accused Termini of committing "dishonest acts" in running the company and refusing to provide him with business records that he needs in order to prepare his will.

Termini downplayed the dispute, saying he had consulted Doherty about Haven's financial investments. But he said Doherty was "not entitled" to the records he was seeking.

Termini conceded that the company's recent patient-care record was troubling, but noted that some Haven homes had no serious deficiencies in the most recent inspections and that problems in Waterford and other troubled homes were being addressed.

He said he had come back to Connecticut full time from Nashville this summer to rebuild the struggling chain and had begun pouring millions into hiring new staff, settling debt and making other improvements.

"We're fighting really hard to turn the company around," he said of the chain, which promotes itself as "A Safe Place to Be." "I'm hopeful the next round of [inspections] will bear the fruits of our labor."

Pulling Punches

Regardless of the reasons behind Haven Healthcare's financial problems, responsibility for policing the possible consequences falls with the Department of Public Health.

From a distance, Connecticut's enforcement efforts look impressive.

The state has one of the highest percentage rates in the country of nursing home inspections that result in findings of serious patient-care deficiencies, according to federal data. The state health department bears responsibility for inspecting homes and determining what state and federal penalties should be imposed for violations.

But a closer look, through the lens of Haven Healthcare, shows that while the state has been aggressive in identifying violations, it has been reluctant to impose the harsh penalties allowed by law and unsuccessful in policing long-term improvements in patient care.

Records show that 10 of Haven's homes — in Torrington, Waterford, West Haven, South Windsor, Norwich, Jewett City, Farmington, Rocky Hill, Danielson and East Hartford — have been fined multiple times in the last three years by the federal or state government, or both. The West Haven, Torrington and

Waterford homes have been cited at least five times each since 2004. Each time, the homes paid the fines and agreed to make improvements, then cycled out of compliance again, sometimes repeating the same offenses.

The most recent federal inspection data show that three Haven homes have at least 24 deficiencies each — double the state average number of violations per home, and triple the national average. The homes in Jewett City, New Haven, Norwich, Rocky Hill and Waterford all were cited for two or more serious violations that caused harm to residents; Waterford also was cited for four deficiencies that caused immediate jeopardy to residents' safety, the highest level of severity.

Among the most frequently cited violations are failures to prevent bedsores, also known as pressure sores, and dehydration — avoidable conditions considered consequences of chronic understaffing.

In the past year, at least nine Haven homes have been cited by the state for failing to prevent and treat bedsores, and five have been cited for failing to monitor residents' fluid intake, state records show. In the most recent federal surveys, 10 Haven homes were found to have a higher percentage of long-stay, high-risk residents with pressure sores than the state or national average, with homes in Cromwell, West Haven, New Haven and Farmington having more than double the national rate.

Despite the deficiencies, Haven Healthcare has continued to receive millions in Medicaid and Medicare funding — more than $130 million last year — making its own decisions about how much to spend on staffing. The chain now has 1,890 beds in Connecticut.

By law, state and federal health officials have the ability to come down hard on nursing homes that put residents' safety in jeopardy. The state Department of Public Health can fine homes up to $5,000 for violations that present an immediate danger of death or serious harm to any resident, and up to $3,000 for violations that pose a likelihood of harm. The state also can terminate nursing home licenses for serious deficiencies or enter into consent orders that carry even larger fines and that require specific improvements.

Federal rules allow for fines of up to $10,000 a day for conditions that place residents' safety in immediate jeopardy. The state also can recommend that funding for new admissions be withheld when homes fail to correct deficiencies, or when serious violations are found in multiple surveys.

But records show state officials have rarely imposed such strong penalties on Haven Healthcare, even in cases where poor care has contributed to death or serious injury. Most of the fines imposed by the state to date have been significantly less than the amounts allowed by state law.

Among the lawsuits filed by families is one that charges Haven's Windham facility with failing to properly monitor the blood sugar level of Rosalie Laroe, an 80-year-old Ashford woman who had diabetes.

Laroe was admitted to the Windham home on Jan. 29, 2003, with a plan of care requiring that she be closely watched for signs of hypoglycemia. But the nursing home staff neglected to notify a physician when she showed signs of low blood sugar, state records say.

In late March 2003, finger-stick tests showed Laroe's sugar levels were falling. A family member reported on March 24 that Laroe was having trouble breathing. On March 27, the staff noted that Laroe's pulse rate was weak and her coloring was pale, but failed to notify a doctor.

Two days later, Laroe was found unconscious in bed, with a critically low blood sugar level. A nurse on

duty "shoved [glucose] medication into her mouth, causing Mrs. Laroe to suffocate to death," the lawsuit filed by Laroe's family charges. She died at Windham Hospital on April 14 of aspiration pneumonia and complications from hypoglycemia.

The state fined the home $935 for the lapses in care, records show. The home also paid a $2,000 federal fine.

This March, Haven Health agreed to pay the Laroe family $555,000 to settle its lawsuit.

Laroe's son, Brian Laroe, and the family's lawyer, Vincent DeAngelo, declined to discuss the lawsuit because of a confidentiality agreement. But Brian Laroe said he still has trouble understanding what happened to his mother, who went into the Windham home for a short stay while her husband, who took care of her, was being hospitalized.

"She was only supposed to be there temporarily," he said. "But the way they treated her, it got bad. ... She'd yell for help, in her loud voice — they didn't like that. They'd make her wait a half-hour or an hour when she called them."

Laroe said he was discouraged to learn that the state had imposed only a minimal fine on the Windham home for the events that preceded his mother's death.

"It seems like just a slap on the hand," he said.

Earlier in 2003, state inspectors had cited the Windham home for similar lapses in care, involving the staff's failure to notify a doctor that a resident's wound was bleeding profusely. The home had agreed to revise its policies to ensure timely notification of physicians.

A review of state records found other cases in which the state cited Haven homes for negligent care, but imposed only minimal fines and did not require any major improvements.

In 2004, for example, Haven's home in West Hartford was cited for two incidents that contributed to deaths. In one case, a resident with dementia who was identified as being at a high risk for falling fell 17 times in seven months, with injuries ranging from bruises to a broken jaw. After falling for the 18th time, the resident became weak and died.

For that incident and another involving a resident who became dehydrated and died, the state fined the home just $950, records show. Federal officials imposed a $3,000 fine.

In October 2006, a Haven home in East Hartford was cited for allowing two residents to become dehydrated to the point they needed hospitalization. The state fined the home $615.

Also last October, Haven's Rocky Hill home was cited for failing to notify a physician of a resident's abnormal blood sugar level. The resident was found unresponsive and having seizures. The home paid a $280 state fine.

In November, the Rocky Hill home was cited for failing to monitor the fluid intake of three residents who became dehydrated. The state fine: $755.

State public health officials said they weigh a number of factors, including the scope of the problems and the home's previous violations, in setting fines. Joan Leavitt, chief of licensing and investigations for the state health department, said the dollar amount of fines is less important than "what we do with

the providers to bring them into compliance."

"It isn't all dollar amounts. It's what we put in to improve quality of care," she said.

Recently, a former medical director of three Haven nursing homes stepped forward to criticize the chain's quality of care. Dr. Cornelio Hong, who served as medical director of Haven's Norwich, Jewett City and Waterford homes, said he had complained last year to both Haven management and the state health department about "the inadequate health care being provided by the Haven facilities," according to a lawsuit he filed in October that seeks $13,000 he claims the company owes him.

In the suit, he charges that the chain reneged on paying him because he was a "whistle-blower" about poor care.

No Success

Only once in the past six years have state and federal officials taken the rare step of suspending government payments to a Haven home in Connecticut for health care violations. And even in that case, the effect was short-lived.

In December, an inspection by state surveyors of Haven Health Center of Waterford found widespread evidence of neglect: Residents were found with bedsores that went untreated or that were covered in urine-soaked bandages. The home was not preventing the spread of infections. A blister on one resident's heel went neglected so long that his leg had to be amputated.

After the inspection, state officials asked the chain's owners to sign a voluntary agreement to stop admissions to the home. Executives of Haven Healthcare said no.

"The President of Haven Health asked [state] managers to take into account the financial resources the ownership is currently putting into the facility," a record of a Dec. 8 meeting says. "The voluntary statement was not signed."

On Dec. 11, state and federal officials suspended Medicare and Medicaid payments to the home, for new admissions only. And in its strongest action to date against the chain, the state in February placed the Waterford home on probation and imposed a $100,000 fine.

But in May of this year, just two months after the suspension was lifted, the nursing home was cited again for some of the same violations, including neglecting a sore on a resident's foot for so long that his toe had to be amputated.

"Multiple issues identified in [the December report] persist," say notes of a May meeting between Haven managers and public health officials.

Nationally, a 2007 study by congressional investigators in the Government Accountability Office found that state and federal sanctions against nursing homes often prompt only temporary improvements, with fines generally so small that some homes viewed them simply as a "cost of doing business."

But other states have had more success in policing Haven Health. Haven owns 10 homes in Vermont, Rhode Island, New Hampshire and Massachusetts.

In Rhode Island, federal and state health officials stopped funding to a Haven home for two months in 2004, after an inspection found multiple deficiencies, including neglect of bedsores. The Rhode Island

home is now rated highly in federal quality surveys.

The state of Maine forced the closing of a Haven Health home two years ago, after an inspection found the staff had neglected residents' bedsores and failed to notify a doctor for two days after a resident was injured in a fall. The home closed down two months after the state and federal government halted funding.

The problems cited in Maine and Rhode Island were comparable to deficiencies found in some Haven homes in Connecticut, federal inspection records indicate.

State and federal officials have rarely used their authority to suspend government payments to Connecticut homes. In the last three years, 23 homes have temporarily lost their funding for new admissions, but most of the suspensions have lasted just a few days, with only three lasting longer than 60 days, federal records show.

Several Haven homes, including Jewett City and West Haven, have been cited two years in a row for deficiencies that caused harm to residents. Ironically, while the chain escaped suspensions in those cases, funding to its home in West Hartford was withheld in September because it failed to remedy fire-safety deficiencies found during a June inspection.

Leavitt, of the state health department, said imposing large financial penalties on homes could end up curtailing the level of care those homes provide, or could prompt owners to appeal the fines in court, tying up the department's limited resources.

"If I put on a $35,000 or $40,000 fine every time I issued [a citation], I might be in court a lot more than I have the resources to be," she said. "I'm not demeaning the fines. [But] there's more value in trying to correct the system."

She also said harsher penalties could force homes to close down, reducing the number of available beds.

"We want to keep the places operating," she said. "We have to look at bed availability."

In recent years, Connecticut has rarely forced a nursing home to surrender its license or prosecuted a home manager or caregiver for neglect. Since 2004, the state has forced only two nursing homes to give up their licenses. One of those homes was Hillcrest Health Care of Montville, where state prosecutors for the first and only time brought criminal charges against a home's corporate owner, in a case in which a resident died after suffering from dehydration, malnutrition and an infection caused by bedsores. The owner pleaded guilty to manslaughter charges.

State health officials said in some cases involving Haven Healthcare, the agency may have referred nursing-home employees to the licensing unit for disciplinary action.

Termini and Haven President Anthony Scierka said they have been working hard in recent months to improve care at the Waterford home and others that have been cited for serious violations. They noted that some other Haven facilities have been free of serious deficiencies, and that the chain's occupancy rate remains one of the highest in the state, at about 96 percent.

Termini said he had no complaints about the Department of Public Health's enforcement program.

"I've never pointed the finger at DPH," he said. "I think they've been fair."

A Predictable Pattern

Inspections of the most troubled Haven Healthcare homes follow a pattern.

State surveyors find violations. The company pays a fine and pledges to correct the problems, sometimes by hiring an independent nurse consultant and agreeing to weekly monitoring. Within a year or two, the problems are back.

Gabrielle Vaillant, a patient in Haven's Danielson home in 2003, got caught in that cycle.

After a March 2003 state inspection, the Danielson home was fined $860 for two incidents in which residents' injuries were ignored. In one incident, an elderly woman who was moved the wrong way by a nurse's aide was forced to wait more than a week, in pain, before she was sent to a doctor and diagnosed with a leg fracture, inspection records show. In the other, a resident who had leg pain and bruising was not sent for an X-ray for 10 days.

At about the same time that the home was paying that fine, Vaillant, 78, slipped while being moved with a mechanical lift. Although she complained of pain when her left leg was touched, the nursing staff didn't notify a doctor until the next day. An X-ray revealed she had broken her leg.

A month later, in May 2003, Vaillant was found lying on the floor of her room. A nurse's aide had lowered a side-rail on her bed and she had fallen out. She broke her collarbone.

The state fined the nursing home $675 in early 2004 for the incidents involving Vaillant, and Haven of Danielson agreed to improve its policies for assessing residents' injuries and using mechanical lifts.

But in 2005, another inspection found a similar violation: A resident injured by a mechanical lift was left in pain for three days before a doctor was notified and an X-ray identified a fracture. The home was fined another $900 by the state and $1,950 by federal officials.

Vaillant's family sued Haven Health, claiming her injuries, as well as a large pressure sore she developed while in the nursing home, accelerated her death in 2004. Haven agreed to a settlement in February, shortly before jury selection was set to begin. The lawyer handling the case, Sandra Baker, would not discuss the settlement because of a confidentiality agreement.

The West Haven home, Haven Health-Soundview, has been cited by the state for multiple instances of neglect of pressure sores and dehydration, dating back to December 2003, when the state issued a detailed "plan of correction" directing the home to improve its patient care. But a year later, in December 2004, the home was again cited for violations, including failing to prevent and treat bedsores and to properly treat residents' injuries, and was fined a total of $9,550.

Two months after state officials again ordered improvements, another inspection found similar deficiencies, and the state and federal governments imposed another $3,900 in fines.

Although state health officials monitored the home through 2006, an inspection in May of this year found some of the same violations, including neglect of bedsores and patients' care plans, and the choking incident involving the woman with swallowing problems. For all those violations, the home was fined $1,350 by the state and $5,000 by the federal government.

The Torrington home was fined $4,000 by the state and $2,600 by the federal government last year for several violations discovered in an April inspection, including inadequate care of pressure sores and

administering psychotropic drugs to residents without an appropriate rationale. In a December 2006 "consent order" signed with the state, the home pledged to correct the deficiencies.

This February, a state inspection found many of the same violations.

Haven Health of West Hartford was cited late last year for failing to conduct respiratory assessments after a patient whose cough was not properly evaluated died. In May of this year, another inspection found similar neglect in tending to a patient with respiratory trouble.

The Haven homes that have cycled most frequently in and out of compliance also have had a high turnover in management staff, according to state records.

The homes in Waterford, Torrington, Jewett City and South Windsor have changed administrators at least three times in the last two years; the home in West Haven has gone through four nursing directors since January 2006, according to records. Haven often moves administrators out of homes after serious deficiencies are found, but in some cases, it has shuffled those same administrators to other homes in the chain.

In the last year, at least one Haven home has gone without an administrator. The state cited the New Haven home in an April inspection for allowing the director of nurses to also serve for six months as the home's administrator, a practice barred by state rules. The home was cited for a litany of patient-care violations.

Besides the patient-care deficiencies, there have been other recurring problems. A number of Haven's homes, including East Hartford, Cromwell, West Haven, Farmington, South Windsor and Windham, have been cited by the state in the last two years for poor building conditions, such as damaged walls in patient rooms and moldy bathrooms, state records show. Haven officials said they have addressed those issues.

In addition, four Haven homes — in Jewett City, Norwich, West Haven and East Hartford — have not yet complied with a July 2006 state law requiring that all nursing homes install sprinkler systems. The Haven homes are the only ones in the state still not in compliance, Leavitt said. The law allows the state to fine homes that don't comply as much as $1,000 a day. But no penalties have been imposed, Leavitt said.

Alice Hedt, executive director of the National Citizens' Coalition for Nursing Home Reform, said that when patient-care enforcement is lax, savvy nursing home owners know they can get away with making only temporary fixes.

"The biggest problem we have is what we call 'yo-yo compliance,'" Hedt said. "Facilities will bring about change after an inspection, but they're not being sanctioned in a way that forces them to make any long-term improvements."

State health officials said they are concerned about repeat violations, which they track closely. But Leavitt said she doesn't believe there's "any one answer" to prompting nursing homes to make long-term improvements.

If fines and monitoring fail, she said, "One would have to take another initiative, after a while."

The One-Dollar Man

To date, the lowest fine paid for a patient-care deficiency involved a nursing home in Greenwich that Haven Health managed in 2004.

That case involved Oscar Aceituno, a 75-year-old resident who had been identified as a wandering risk, with a plan of care directing the staff to check on him every hour and ensure that he wore a "wander bracelet," according to state records.

Susana Aceituno had placed her husband of 50 years in the home on May 14, 2004, to keep him safe. At age 75, he had advancing Alzheimer's disease. She said his condition had progressed to the point that she could not even go to the bathroom without first calling a nearby daughter to watch him. She reluctantly decided to put him in a nursing home after police found him wandering on a busy New York expressway.

Oscar was not in frail condition when he was admitted, Susana Aceituno said. In fact, the couple had danced a tango for the other residents on his first day at Haven Health Center of Greenwich, she recalled.

During his stay, Oscar Aceituno repeatedly removed his Wanderguard bracelet and left the building, according to a lawsuit the couple has filed against the nursing home chain. On May 18, Susana Aceituno made arrangements to have her husband transferred to a more secure facility nearby, but canceled the plans after Haven's managers assured her he was adjusting well, the suit says.

Then, on May 30, a nurse's aide noticed Aceituno outside the building and brought him back inside. Twenty minutes later, he bolted outside again, according to state records.

He was found lying in the dirt, with an injury later identified as a cervical cord contusion.

He has since been confined to a wheelchair.

"You have no idea how strong this man was," Susana Aceituno said of her husband, who now resides in another nursing home. "Today, there's nothing there. He doesn't walk. He never walked again. He doesn't talk. He has to be fed. He has diapers.

"I look in his eyes but he doesn't look at me. He looks far away," she said. "This is what they gave me back."

Attorney Joshua Koskoff, who represents the couple, called the facts of the case "egregious," noting that Oscar Aceituno's wandering was the reason the family chose to entrust him to Haven Health.

Like other lawyers who have sued Haven homes, Koskoff said he and co-counsel Tom Rhodes are trying to navigate the chain's complex corporate maze, which consists of numerous limited-liability nursing home corporations.Haven's lawyers already have claimed the Aceitunos sued the wrong entity.

State inspectors cited the Greenwich home in December 2004 for failing to properly monitor Aceituno, who had been identified as a serious "elopement risk." The state imposed a fine of $615.

But because the nursing home was in bankruptcy at the time, the financial manager assigned to the home contested the fine, saying it would create "an undue hardship on the state of Connecticut and its taxpayers."

He sent the state a check for $1.

Contact Lisa Chedekel at lchedekel@courant.com.

Copyright © 2008, The Hartford Courant

courant.com/news/custom/topnews/hc-haven2.artnov19,0,1950371.story

Courant.com

A COURANT SPECIAL REPORT: Second of Three Parts

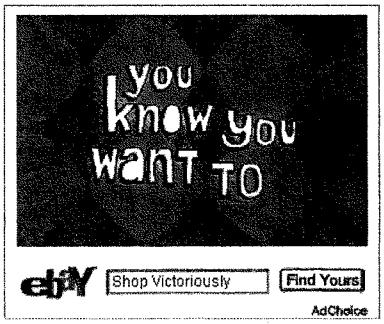
State Soft On Nursing Levels

Minimum Staffing Rules Unchanged In 25 Years

By LISA CHEDEKEL

Courant Staff Writer

November 19, 2007



Billy Bogardus of West Hartford went into a Haven Healthcare nursing home to recuperate from a hospital stay, but ended up fighting for his life.

For four days in April, Bogardus and his close friend, Leona Brenner, tried to convince the staff of the Haven Health Center in South Windsor that he was dying. Bogardus, who had sought nursing-home care after complications from heart surgery, was coughing, struggling to breathe and couldn't walk the six steps from his bed to the bathroom, he and Brenner said.

Only after Brenner threatened to call 911 herself did the nursing staff finally summon an ambulance, the couple recounted. By the time the 69-year-old retired civil engineer arrived at St. Francis Hospital and Medical Center in Hartford, hospital records show, he was dehydrated and his kidneys were failing.

"If it wasn't for [Leona], I'd be dead half a dozen times," said Bogardus, who landed in the hospital several other times during his seven months in the nursing home — once when a blood test found his level of the medication Cumadin was five times higher than normal. "You had to beg and plead to get them to pay attention. I think I would've been better off out on the street."

Bogardus' complaints were not new. Last year, a state inspection report detailed numerous patient-care lapses at the South Windsor home, citing complaints from residents about the "difficulty they have experienced in obtaining staff assistance."

The South Windsor home is one of 13 Haven Healthcare homes with staffing levels that fall below both state and national averages, according to the most recent federal data. Nationwide, nursing homes provide an average of 3.6 hours of care per resident per day — 1.3 hours by licensed or registered nurses, and 2.3 hours by certified nursing assistants. A study commissioned by the federal government recommends that each resident receive 4.1 hours of care a day.

But in Connecticut, nursing homes have had little incentive to boost staffing. The state's minimum-staffing law, which has not been updated in more than 25 years, requires only 1.9 hours of nursing care a day per resident — less than half of what the Centers for Medicare & Medicaid Services' study recommends.

Although the state's public health code also requires that each facility has sufficient staff to ensure residents receive appropriate care, state public health officials have been reluctant to use that provision to penalize homes for understaffing, or to make demands on homes to add staff when deficiencies are found, records indicate.

Federal data show that Connecticut in 2006 cited only 2 percent of nursing homes, under federal rules, for failing to provide sufficient nursing staff — a lower rate than 27 other states. In 2005, its rate of citing homes for staffing deficiencies was among the lowest in the country — zero.

Haven Healthcare — which has the lowest staffing average of the state's three largest chains, according to the most recent data — is one of many nursing home operators in Connecticut that stand to benefit from those policies. But it also provides some compelling examples of the consequences.

Many of Haven's 15 homes in Connecticut have been cited in the last three years for bed sores and dehydration — two key indicators of understaffing, according to federal health officials and nursing home experts. In February, the chain's Waterford home was hit with the largest penalty imposed by the state in three years — a $100,000 fine and two years' probation — for neglecting a sore on a resident's heel for so long that his leg had to be amputated, in addition to other violations.

But in most cases where Haven has been cited for bedsores or dehydration, state officials have not mandated any increase in staffing. Even in the Waterford case and two other Haven cases that triggered "consent orders" by the health department — the highest level of enforcement — the department did not require increases in staffing ratios.

In a number of cases where serious patient-care deficiencies have been found in Haven homes, follow-up state monitoring often consists of the assertion: "Staffing was reviewed and found to be in compliance with the minimum staffing levels of the public health code" — a certification that nursing home advocates say is meaningless.

"It says nothing. It means nothing," said Jane McNichol, executive director of the Legal Assistance Resource Center of Connecticut, who has been active in a coalition pushing to increase staffing. "Even the worst homes exceed the state requirements."

Jennifer Keyes-Smith, an advocate for the elderly who formerly worked for the state as a regional nursing home ombudsman, complained in a letter last winter to the attorney general's office that she had tried repeatedly several years ago to get the ombudsman's office and the state Department of Public Health to address chronic understaffing at Haven's New Haven home — without success.

"I continued to visit the facility and observed resident call bells going unanswered, residents not being fed, residents not being toileted, and staff treating residents disrespectfully," she wrote last November. "With basic human needs not being met, I continually urged the program's prompt intervention and DPH's expedient response. I was then told to stop working on the case."

Most nursing homes in Connecticut far exceed the state minimum, averaging about 3.7 hours of care a day. But the state's lack of enforcement on staffing opens the door to some homes to reduce staff, with few consequences, patient advocates say.

The most recent data reported by the federal government — based on surveys now several months old — shows that Haven's Farmington home does not provide even two hours of care a day to residents, while staffing levels in its New Haven home actually fall below the outdated state minimum, with just 1.6 hours of nursing care a day. An April state inspection of the New Haven home found 31 deficiencies, including neglect of bed sores, triggering a $6,000 federal fine.

Asked last week about the below-minimum staffing at the New Haven home, officials in the health department's licensing unit initially told The Courant that the federal data was erroneous. "Nobody staffs to the minimum," said Joan Leavitt, chief of licensing and investigations.

They later acknowledged there was no error in the data.

Haven Healthcare CEO Raymond said he could not recall the state ever punishing the chain for understaffing or mandating higher staffing ratios.

He blamed "years and years of inadequate Medicaid funding" for impacting staffing, saying he was not satisfied with staff levels in some Haven homes.

He said he made a decision this summer, after the findings of poor care in Waterford and New Haven, to devote $10 million to hiring about 200 new workers. He and Haven President Anthony Scierka said those hirings have begun and have boosted average staffing levels in the 15 homes to about 3.7 hours of care a day per patient — the state average.

"No one mandated this. It's my own initiative," Termini said.

Last week, state Attorney General Richard Blumenthal disclosed that state and federal officials were investigating whether Haven Eldercare, the chain's parent company, improperly diverted government funds away from patient care. Termini said the company's financial issues never impacted the level of care.

The public health code's general rules on staffing mandate that nursing homes provide enough staff to ensure that each patient receives appropriate treatment, is "comfortable and well-groomed" and is protected from accident or infection. Federal rules also require sufficient staffing.

Efforts to update the code to increase the 1.9-hour minimum have repeatedly failed to pass the state legislature in recent years, under lobbying pressure from the nursing home industry. The public health department drafted regulations in 2000 to increase staffing minimums to 2.48 hours a day, but they were never enacted. More recent efforts also have failed.

Nursing home owners have opposed increasing the minimum, saying there is a shortage of qualified nursing personnel to work in the homes, and that state Medicaid reimbursements are not adequate to cover increased staffing.

State health officials say they address staffing deficiencies in nursing homes in other ways than by directly citing state or federal provisions requiring "sufficient" nursing staff.

"Saying they don't have sufficient staffing is not the whole end," Leavitt said. "It's not just the numbers; it's the quality of care."

She said the state often addresses staffing issues by citing homes for violating another provision of the

health code that describes the duties of nursing directors, which include deploying nursing staff to meet patients' needs.

"Without supervision, the numbers [of staff] mean nothing," she said.

But the numbers remain a key indicator of quality for federal officials and nursing home advocates. And other states do require troubled homes to increase their staffing levels when inspections find bedsores, dehydration or other signs of inadequate care.

Connecticut's 1.9-hour minimum now ranks as one of the lowest among states that legislate minimum staffing — so low that it prompted this reaction from Alice Hedt, executive director of the National Citizens' Coalition for Nursing Home Reform, a leading advocacy group:

"Oh, my God. You've got to be kidding."

A Barometer of Quality

In the past year, at least nine Haven homes have been cited by the state for failing to prevent and treat bedsores, while five have been cited for failing to monitor residents for dehydration, according to state records.

Nursing home experts say bedsores and dehydration are often consequences of chronic understaffing. Federal health officials use the incidence of pressure sores as a measure of nursing home quality.

Bedsores are painful skin ulcers caused by constant pressure on a part of the body, common among people left in a bed or wheelchair for long periods of time. Nursing homes can prevent the sores by frequently changing a resident's position or providing padding. In their early stages, the sores can be easily treated. But left unattended, they can infect underlying tissue, bones and joints.

In recent surveys, 10 of Haven's 15 homes were found to have a higher percentage of high-risk, long-term residents suffering from pressure sores than the state or national average of 12 percent. Thirty percent of residents in the West Haven home, 28 percent in Cromwell and 27 percent in Farmington were found to suffer from pressure sores.

The incidence of pressure sores "is a major barometer of quality of care. It's one of our chief concerns," said Roseanne Pawelec, spokeswoman for the Boston office of the Centers for Medicare & Medicaid Services. "It can be an indicator of several issues, including understaffing, poor training and insufficient monitoring of residents."

State health officials in February imposed a "consent order" on Haven's Waterford home for violations including the incident leading to amputation. The state found the home had failed to monitor and treat a blister on a resident's heel for two months, as it erupted into a pressure sore. A state inspector visiting the home last November saw the wound, which was covered in a bandage saturated with dried blood and giving off a "foul odor," and intervened.

On Dec. 4, the resident's leg was amputated below the knee.

In the consent order issued to the Waterford home, state health officials made a reference to staffing. In addition to requiring weekly monitoring by a nurse consultant and the hiring of a wound control consultant, the order calls on the home to identify the number and qualifications of nursing and other staff "necessary to meet the needs of patients," and to ensure that "sufficient nursing personnel are

available."

The same language is in the state's public health code.

In addition to bed sores, the failure to monitor residents' fluid intake has been a frequent finding.

In January 2004, a resident of Haven Health Center of West Hartford who was supposed to be watched for dehydration grew weak from lack of fluids and died, with inspectors finding that the resident's fluid intake was not properly monitored.

This spring, Haven's homes in Rocky Hill, Waterford and Norwich were fined for failing to monitor fluid intake, after residents in those homes became dehydrated. Haven's home in Farmington was cited for the same lapse in monitoring in February; the East Hartford home was cited for two similar incidents last October.

Several lawsuits filed against Haven Healthcare make mention of bedsores and dehydration. The family of Carrie Tondalo, who resided in Haven-Soundview in West Haven in 2003, has a lawsuit pending that alleges the nursing home failed to monitor her fluid intake or skin sores for three months leading to her death, despite directives that those conditions be addressed. The health department's investigative report into her death, which concludes that the home failed to properly monitor Tondalo's condition, also mentions other cases in which residents' bedsores were neglected.

"Our case is solid," said Anthony S. Bonadies, a Hamden lawyer representing Tondalo's family. "What gets me is how many people this happens to, but they never come forward."

More Consequences

Other patient-care violations, some of which have resulted in death or serious injuries, also point to understaffing.

State inspectors cited Haven's West Hartford home last year for failing to properly monitor residents' respiratory conditions, after the staff gave cough medicine to a resident who was struggling to breathe but did not do any further evaluation for three days. The resident later died.

Haven's home in Norwich was cited in June for not tending to a resident who fell to the floor one night and complained of leg pain. The resident was not taken to the hospital for evaluation until late the next day, when an X-ray revealed a fracture.

The Cromwell home was cited last year for not responding when an oxygen line broke on a humidifier used by a woman with a tracheotomy, and she tried to alert the nursing staff that she couldn't breathe. She was found unresponsive the next day and rushed to the hospital.

In a wrongful death lawsuit filed against the nursing-home chain, the family of a woman who resided in a Milford nursing home that was managed by Haven Health in 2003 alleges that she died because the home repeatedly ignored her severe bowel problems.

Geraldine "Gerri" Hart had entered Haven Health of Milford, formerly known as the Golden Hill Health Care Center, in July 2003, after the nearby Pond Point facility in which she had thrived had closed down. Hart, 56, required full-time care after a series of strokes. She was placed on pain medications known to cause constipation, with a treatment protocol calling for her bowel function to be monitored, the lawsuit says.

But the nursing staff failed to address her constipation for weeks, a state inspection report found. By the time she was rushed to Milford Hospital on Oct. 9, 2003, Hart was vomiting brown fluid, and more than a cup of fecal material was suctioned from her lungs. Within hours of admission, she was dead of a perforated bowel, resulting from fecal impaction.

"I could see when she went to Haven Healthcare, she was going downhill," said Marilyn Tarczali, Hart's younger sister, who brought the lawsuit. "It was just awful there. She was in bed all the time. The laughing had stopped. ...

"Nobody ever said a word to me that she wasn't going to the bathroom," she added. "To die like that, because they were too lazy to give her a suppository."

Tarczali's lawsuit also targets Milford Hospital, which sent Hart back to the nursing home twice in the days before her death, even though X-rays showed she was suffering from fecal impaction.

Haven Health took over Golden Hill on Aug. 1, 2003, soon after Hart was admitted. It ended its management of the home on Nov. 30, according to state officials. The state health department fined the home $3,000 in 2004 for a number of violations, including the lapses in care that led to Hart's death.

Haven officials would not comment directly on pending lawsuits, but pointed out that they had managed the Milford home and several others cited in negligence lawsuits for only a short time.

Making The Link

In 2006, Connecticut's average staffing was 3.6 hours a day — slightly above the national average, but lower than 21 other states. Staffing levels among Connecticut homes swing widely, from less than two hours of care per day to more than four hours.

Charlene Harrington, a professor of sociology and nursing at the University of California-San Francisco and an expert on nursing home staffing, said some states, such as Florida and Maine, have set relatively high minimum-staffing standards. Florida requires 3.9 hours of nursing care a day.

But she said many states have no interest in policing staff levels, which can require more time and resources, as well as increases in Medicaid funding.

"It's a lack of commitment, because they think if they go after the pressure sore, that's enough," Harrington said. "They don't bother addressing the underlying problem" of staffing levels. "So the same problems just keep coming up. It never gets any better."

Deborah Chernoff, spokeswoman for the New England Health Care Employees Union, District 1199, which represents workers at 11 Haven homes, said staffing levels at some of the homes had reached "disgraceful" levels in past years.

"It's hard on our members," she said. "There's a very high injury rate when you don't staff adequately."

Termini said he approached Leavitt this summer with his plan to add 200 new workers, because of concerns about the findings of poor patient-care in some Haven homes. He said the chain was devoting its entire $3 million Medicaid increase, along with $7 million in other funds, to boosting staff.

"I'm of the personal belief that staff levels are never high enough," he said.

Termini insisted that staffing levels at Haven homes have not suffered because of the chain's recent financial problems. The chain has defaulted on millions of dollars in unpaid bills for medications and other supplies, according to lawsuits filed by creditors. In addition, Termini has used some of the company's proceeds from real estate refinancing to launch a Nashville record company and make other investments.

"No patients have been adversely affected by our circumstances," he said.

Haven officials said they recently had reduced the number of beds at the South Windsor home, where Bogardus was a resident, in an effort to improve patient care and boost staffing levels.

Courant Staff Writer Lynne Tuohy contributed to this story.

Copyright © 2008, The Hartford Courant

courant.com/news/custom/topnews/hc-haven3.artnov20,0,2146972.story

Courant.com

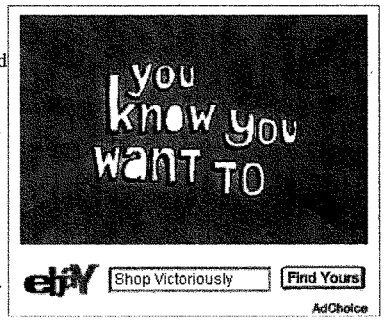
A COURANT SPECIAL REPORT: Third of Three Parts

Haven Debt Woes

BY LISA CHEDEKEL And LYNNE TUOHY

Courant Staff Writers

November 20, 2007



In late 2005, Haven Healthcare CEO Raymond Termini decided to pursue a longtime dream: He launched a record label in Nashville to produce both little-known and established country musicians.

Within months, Category 5 Records would come up with enough cash to sign two-time Grammy winner Travis Tritt and singer-songwriter Sammy Kershaw.

Back in Termini's home state, residents of his nursing home in Jewett City spent a cold December night. After months of not being paid, the company that supplied heating oil to the nursing home had suspended deliveries.

"[The] facility had a history of delinquent oil payments despite multiple requests for payment, and oil delivery was placed on hold in October 2005," state Department of Public Health records say. One night in December, the home ran out of oil, with the night supervisor reporting "cold air temperatures." The chain promised to pay, and delivery resumed.

In the last two years, the Jewett City oil bill has been the least of Haven Healthcare's debt problems. The chain, which owns 15 nursing homes in Connecticut, has become mired in debt litigation, with at least a dozen creditors seeking more than $20 million in unpaid bills for medication, oxygen and other supplies, according to records.

Earlier this year, the chain's financial situation prompted nurses at Haven's home in Rocky Hill to write a letter to Termini and other Haven executives, complaining that: "The situation is dire, and the residents are suffering as a direct result of this company's refusal to invest any time, finances or interest in this facility."

The nurses said that in addition to chronic understaffing, the facility had shortages of juices, diabetic snacks and some medical supplies.

"Our suppliers refuse to deliver due to a lack of payment," they wrote in an April 25 letter. "We ran out of gloves and insulin syringes; the staff has had to improvise dressing changes, utilizing expired materials for a lack of supplies. The cable was disconnected due to nonpayment. The nurses refuse to

risk their hard-earned licenses any longer."

Termini, in an interview last week, insisted that the chain's cash-flow problems had not affected patient care in his nursing homes, 10 of which have been cited for serious deficiencies in the last 15 months. He blamed the debt problems on "inadequate" state Medicaid funding.

But a review of court and state records raises questions about how the chain has managed its money.

In documents filed earlier this month in Superior Court in Middletown, the Rev. Edward C. Doherty, Termini's longtime business partner and former mentor, claimed that Termini had used assets from Haven's parent company, Haven Eldercare, for personal gain, and had committed "dishonest acts" in managing the company. The petition claims Termini improperly diverted Haven Eldercare assets into his country-music record label and the purchase of a lakefront house in Middlefield, among other things.

In addition, a lawsuit filed by a major pharmaceutical supplier alleges that the Haven chain collected millions in Medicare reimbursements for pharmacy supplies, but never turned that money over to the company. The supplier, Value Health Care Services of Cheshire, an affiliate of Omnicare Inc., sued Haven earlier this year, claiming the company had failed to pay $20 million owed for pharmaceutical supplies and services dating to 2004.

Termini and Haven's chief financial officer, Michael Lipnicki, insisted last week that the company had not misused any government funding. Lipnicki said all Medicare and Medicaid money that the company had received had gone into operating the nursing homes.

But the company's financial problems have raised concerns at the state Department of Social Services, which oversees state nursing home funding. Agency officials said last week that they had launched an examination of Haven's records in September to determine whether the company's financial condition constitutes an "emergency situation that warrants the appointment of a receiver to safeguard resident health and safety."

On Monday, Gov. M. Jodi Rell said receivership for certain Haven homes or the entire chain "may well be the only way to guarantee improvements in the conditions at these homes," and she wanted a decision on possible action by Dec. 1.

"The people of Connecticut deserve to have confidence that the elderly and infirm will be treated with the dignity and compassion they deserve," she said in a statement. She said stories in The Courant "serve to highlight the unacceptable, poor conditions" in some Haven homes that recently had been brought to her attention by the commissioners of social services and public health.

Attorney General Richard Blumenthal said his office also has been investigating Haven Healthcare, in conjunction with federal officials, in an effort to determine whether the company improperly funneled government funding away from patient care, into "other financial enterprises."

Blumenthal said the probe is focusing on "potential financial irregularities and other improper conduct that is likely to produce civil action and even possible criminal ramifications." He said any evidence that Haven "either misreported expenses or used federal and state funds for purposes unrelated to the nursing homes" could lead to fraud charges.

"No health care institution can stiff their vendors or shortchange their suppliers in paying bills that are supposed to be paid out of government funding," Blumenthal said.

Termini insisted that the probe would turn up no evidence of wrongdoing.

"We have not done anything even remotely wrong or improper," he said. "At the end of the day, they're going to come up empty."

'A Series of Schemes'

On the Category 5 website, Termini bills himself as a Connecticut entrepreneur whose "business acumen allowed him to turn a small business into a powerful regional enterprise."

"Powerful" was once an apt description of Haven Healthcare, which sprung up quickly, under the Roncalli Health Care name, in the late 1990s.

Termini, an East Haven native and accomplished musician, said he befriended Doherty while working as a roofing project manager on a job at St. Clements Estate in Portland, which Doherty ran. Within months, Termini was helping Doherty operate two nursing homes that were owned by Doherty's Roncalli Institute and was laying plans to expand Roncalli's chain in Connecticut and other New England states.

"I got bit by the bug," Termini said last week as he recalled his introduction to the field of elderly care. "I felt something that was very, very real and I wanted to help."

Termini said he set his sights on "rescuing" troubled and bankrupt nursing homes, buying 15 homes in Connecticut and a dozen in other New England states within a few years. In 2003, Haven Eldercare made a bid to buy nine more homes in Connecticut that were run by the Mediplex chain. The deal fell through. At the time, state social services and public health officials expressed concerns about the "financial viability" of Haven, citing the company's fast expansion, according to correspondence.

In his recent court filing, Doherty claims that Termini and another partner, Barry O'Doherty — Doherty's nephew — breached their contract and financial obligations to the nursing homes' parent company and violated the Connecticut Unfair Trade Practices Act. Doherty wants the court to order Termini to surrender Haven's business records to him.

In filings with the state public health department, Haven Eldercare lists Termini and Doherty as equal partners, each with a 40 percent interest, with O'Doherty holding 20 percent. But Doherty claims that Termini and O'Doherty violated the partnership's operating agreement by expanding the nursing home chain and by seizing 90 percent of the interest in the company.

"Termini and O'Doherty have engaged in a series of schemes, transactions and artifices to freeze out, deceive and harm Doherty," the petition claims. It cites the use of Haven Eldercare assets for the record company and lakefront house, as well as a food-service business that Termini launched to pare the cost of meals by having food prepared off-site for the nursing homes.

In a statement released by his lawyer, William McGrath, Doherty said he was undergoing cancer treatment and had divorced himself from the management of Haven Eldercare in 2002 after suffering a stroke. He said he began seeking financial records from Termini several years ago in order to prepare his will.

"I have never been provided with the information requested, which is the reason I have recently sought relief from the court," Doherty said.

Termini downplayed Doherty's claims, calling the matter a "partners' dispute." He said he had informed Doherty about the investments made through Haven Eldercare, but also said Doherty was "not entitled" to the records he was seeking.

Termini acknowledged last week that he had used assets of Haven Eldercare to finance Category 5 Records and a house on Lake Beseck, but said there was nothing improper about the use of funds. He and Lipnicki said the money for the record label had come from refinancing Haven homes in other New England states, not from Medicaid or Medicare. He said he had purchased a $2.1 million building in Nashville last December for Category 5 with his own money.

Termini insisted that his use of Haven Eldercare assets was well-intentioned. He said that while launching a record company was a longtime dream of his, "the company invested in non-health care companies in order to gain a return, in order to help subsidize the health care chain. I don't believe Category 5 had any effect on Haven Healthcare's [finances]."

Records show a subsidiary of Haven Eldercare called Lake Beseck Equities, run by Termini, purchased a lakefront house in Middlefield in 2003 for $485,000. Termini owns another house in Middlefield, which had been his full-time residence. He said last week that he had moved into the Lake Beseck house a short time ago and was living there now. Lipnicki said Termini recently purchased the house in his own name.

'Unfulfilled promises'

As Termini has used Haven Eldercare to launch other ventures, records show his nursing home chain has accumulated millions in debt for supplies and services.

The largest debt litigation is Omnicare's claim that Haven failed to pay $20 million for pharmaceutical supplies and services dating to 2004. Termini and Lipnicki did not dispute that the bills were owed, and said they were finalizing a repayment agreement with the company.

Lipnicki acknowledged that the chain had collected federal Medicare reimbursement for the pharmaceutical expenses without turning over the money to Omnicare.

"The Medicare reimbursements went into other [operating] shortfalls," Lipnicki said. He said the chain was allowed to use the government funds for other patient-care expenses, and he claimed that Omnicare had "willingly allowed us not to pay all their bills."

But in its lawsuit against Haven, Omnicare said it had agreed to carry only $5.5 million of Haven's outstanding debt as a loan, and had repeatedly sought payment of the rest. Officials of Omnicare and the company's lawyer said they could not comment on the litigation.

Omnicare went to court against Haven in March, after what it said were Haven's "numerous unfulfilled promises to pay." Just four days before the lawsuit was filed, Haven's president, Anthony Scierka, sent Omnicare a letter saying the chain was scrapping its contract because Haven had uncovered "improper and fraudulent billing practices" that resulted in "millions of dollars of overcharges."

Omnicare denied those allegations, calling them "manufactured."

Last week, Lipnicki said Haven and Omnicare were in the process of settling their dispute, with

Omnicare agreeing to erase about $1.5 million of the debt, and had signed a new contract. He said delivery of pharmacy supplies had not been disrupted during the legal fight.

State social services officials said last week that their concerns about Haven's financial health were longstanding and rooted in the company's delays in paying bills and its requests for advance payments of Medicaid funding and for Medicaid rate increases.

But it wasn't until Sept. 20 that Social Services Commissioner Michael Starkowski called for a financial probe of the company to determine whether receivership was warranted. In calling for the review, Starkowski cited concerns that Haven had failed to pay a $228,000 malpractice settlement that was due in May, and that it owed another $635,000 in provider fees that were due to the state on July 31. He also said that four Haven homes were the only nursing homes in Connecticut not in compliance with a July 2006 law requiring automatic sprinkler systems.

Several recent audits have identified Medicaid reimbursements that Haven never applied to bills. A state audit in March of Haven's Danielson home identified $119,000 in unpaid expenses that were subsequently disallowed. In September, the state identified $209,000 in claims by Haven of Farmington that had not been paid.

Social Services records show that the chain set aside about $7.3 million for management fees in 2006, in addition to the costs of staff salaries at each of the homes. Lipnicki said the fee rate was standard for the industry, adding that Haven had turned a profit in 2006.

Still, court and state records show Haven repeatedly has defaulted on paying its bills, even for basic utilities.

In January 2006, Connecticut Light & Power notified the state health department that its yearlong effort to get Haven Health to resolve a "sizable delinquency" had failed, and it was threatening to shut off electric service to six Haven homes. A few days later, CL&P withdrew the warning, with Lipnicki and other executives assuring the state that the chain had no other outstanding financial problems.

But a month later, in February, CL&P filed suit against Haven Health for more than $6,400 in outstanding electric bills, from 2002 through 2004, for its home in Greenwich. Haven was ordered to pay the debt, according to records.

Among the other lawsuits filed in the last two years, some of which Haven has settled in recent months, is a claim by Sten & Barr Medical Inc. of Florida, a distributor of beds and other medical equipment, for $63,000 in unpaid bills dating to 2005. In September, a judge directed Haven to pay off that debt over five months.

Last month, Haven agreed to pay $245,000, in installments, to settle its debt to Technical Gas Products Inc. of Connecticut, which provides oxygen tanks and other equipment. Haven also recently agreed to a settlement with a Milford law firm, Berchem, Moses & Devlin, which filed suit in March seeking $23,400 in unpaid legal fees.

Other debt litigation is still unresolved. It includes a lawsuit filed in August by a Florida company called Medventures Consulting, which is seeking up to $2.4 million from Haven as a fee for helping the chain identify possible overcharges by Omnicare.

In a lawsuit filed in October, a former medical director of three Haven homes charged that he is owed $13,000 for services he provided from December 2006 through June 15 of this year. In the suit, Dr.

Cornelio Hong claims that Haven received reimbursement for his services, but has "utilized the funds for its other purposes, in a practice sometimes known as accounts payable financing."

The state of Maine is seeking more than $1.5 million from Haven in overdue reimbursements, said Herbert Downs, audit director for the Maine Department of Health and Human Services. In addition, the chain owes the federal government more than $100,000 in civil penalties dating to 2004.

Even the Stamford law firm representing Haven in several malpractice cases has had trouble getting paid, filing motions in January and October to withdraw from representing the chain. Lawyers familiar with the cases said the withdrawals were triggered by nonpayment.

In recent months, Haven has settled three negligence lawsuits — one for $555,000, another for $228,000 and a third for an undisclosed amount. But the company delayed paying two of those settlements for months, until lawyers went back to court to hold the chain in default.

Termini and Lipnicki said the state had been aware of the company's cash-flow problems for years, and they insisted that the debt problems had never affected patient care.

Termini said the company was working out a refinancing plan that he hoped would allow it to pay off its creditors in the coming months. He also said the chain was spending $10 million to hire about 200 workers, to improve patient care.

Termini said he returned to Connecticut full time in July to help rebuild the struggling company after spending much of the last year in Nashville. In 2006, he had promoted Scierka from senior vice president to president of Haven Healthcare.

"I built a very deep company and I stepped out of my capacity as president ... to pursue a dream," he said. "My focus was not on the day-to-day operations."

Now, he said, "my full focus is right here."

Social Services spokesman David Dearborn said Monday that receivership would entail the state going into court and arguing that appointment of an interim manager of the homes would be in the best interest of the residents and the taxpayers.

In response to the threat of receivership, Termini issued a statement saying he was confident that the state's review would show that Haven is "one of Connecticut's best Healthcare providers and is being wrongfully attacked in an effort to sensationalize the unfortunate and objective realities faced by the nursing home profession."

Stepped-Up Collections

As creditors have lined up against Haven, the chain has stepped up its efforts to collect on its own unpaid bills, filing lawsuits against elderly residents that seek payments for care not covered by Medicare or Medicaid. In some cases, Haven has gone after the residents' only assets — their homes.

In one case, Haven Health Center of Farmington in September secured a court order to attach the Bristol home of a resident, Arthur Pelkey, for $105,000. Pelkey's wife still lives in the house.

In another case, an attorney for Sara Tucker, a resident of Haven of West Hartford, notified a Hartford

judge in July that he was selling off her house in Enfield to satisfy a nursing home debt of more than $128,000.

In some cases, Haven has sought to have conservators named for residents, as it pursues payments for uncovered costs. In one such case, Haven Health Center of East Hartford pushed this summer to have a conservator named for 87-year-old Rose Quattro, over the objections of her son, and sought court approval to place a $50,000 lien on the house that the two share.

James Quattro, a self-employed mechanical contractor, said his mother was sent to the Haven home in March to recover from an infection that had landed her in Manchester Hospital. He expected she would be back at home within a few weeks. But he said the nursing home was reluctant to discharge his mother, setting a list of conditions that included ensuring she had around-the-clock care — something he said the home itself was not providing. Haven maintained that James Quattro was uncooperative in arranging a discharge plan.

With the case tied up in court, Rose Quattro remained in the nursing home until a week ago, when she was finally allowed to return home. Records show Haven had been billing his mother about $350 a day since June, when her Medicare benefits ran out and the legal battle began, and is now seeking more than $50,000.

"Every hearing they had, I asked, 'Why hasn't she been sent home yet? Why are they doing this to her?'" Quattro said of his mother, who was a longtime secretary in East Hartford's town hall. "It's like they've got the vacuum turned on, and they want to suck up everything we have. It's unbelievable to me."

Termini said the company's efforts to collect unpaid bills, or to pursue conservatorship in some cases, were standard practice in the industry.

Wads Of Cash

Unlike Haven Healthcare, there are no outward signs that Termini's record label has run into money troubles. Last December, Termini purchased a Music Row building for the company that houses a recording studio originally built by Roy Orbison.

On the Category 5 website, Termini explains that he named the company in remembrance of a hurricane that prompted him to go to Florida to relocate his yacht, leading to his encounter with a musician, Craig Hand, who was performing in a coastal diner.

"Termini found himself inspired to develop an aggressive business plan for a record label," the website says. He gathered "an established group of industry professionals and signed visionary artists."

The site describes Termini as "an accomplished musician ...[whose] love for music was nurtured from an early age in his father's nightclub."

In a July 2006 story, Billboard magazine said Termini's record label had spent "wads of cash for signage and sponsorship" at a country radio gathering that February and had signed Tritt and Kershaw "reportedly for big bucks."

Hand was the first artist signed by Category 5. In a biography on his website, he describes Termini pitching him to join the new label.

"This worked out better than I ever would have thought," Hand says. "The determination these guys have to make it work at all costs — let me tell you, Ray Termini isn't the kind of guy who settles for not quite good enough."

Copyright © 2008, The Hartford Courant

courant.com/news/custom/topnews/hc-alarmraised-1218,0,7528906.story

Courant.com

Haven Alarm Raised In '06

Blumenthal's Office Urged Receivership

By LISA CHEDEKEL

The Hartford Courant

December 18, 2007

The state attorney general's office recommended more than a year ago that the Department of Social Services pursue putting Haven Healthcare into state receivership because of its questionable financial dealings, but the advice was not heeded until this September.

Attorney General Richard Blumenthal said lawyers in his office advised senior social services officials in June 2006 to seek a court-appointed overseer for the nursing-home chain because of signs that the company was "heading for financial disaster." Blumenthal said the concerns stemmed from the chain's growing debt and findings that Haven officials were diverting millions of dollars in corporate assets into personal ventures.

"Our attorneys very emphatically recommended that a receiver be sought and that it be done right away," Blumenthal said Monday. "I can't speak to what considerations prompted DSS to wait, but they did."

He said lawyers in his office recalled a June 15, 2006, meeting at which they advised "senior officials" of the social services agency to pursue receivership. His office repeated that recommendation "in multiple meetings and telephone conversations thereafter," Blumenthal said, while also advising the social services agency to withhold discretionary Medicaid increases from Haven.

Blumenthal disclosed the recommendation in response to questions from The Courant about an April 2006 financial review of Haven Healthcare by the social services department that raised serious concerns about the chain's financial dealings. That review, which was given to Social Services Commissioner Michael P. Starkowski - then the agency's deputy commissioner - found that company CEO Raymond Termini had used more than $5 million in corporate assets to launch a Nashville record company and buy three Connecticut apartment buildings and a yacht.

At the same time, Haven was defaulting on bills for basic supplies and utilities, and some of its 15 Connecticut homes were cited by state health officials for serious patient-care deficiencies.

"A substantial amount of cash ($5,800,000) has been transferred out of the corporate entities for the

personal benefit of the principals," the 2006 review found. The report deemed the transactions "disconcerting" and grounds for concern about "the financial stability of Haven."

But social services officials did not pursue state receivership until this September, when Starkowski ordered another financial review of the chain after news reports that Haven had defaulted on a malpractice settlement.

That financial review, which was delivered to the governor Dec. 3, rehashed many of the findings of the 2006 audit, but this time the agency found grounds for putting Haven into state receivership. By then, however, receivership was no longer a viable option because the chain had filed for bankruptcy in late November.

During bankruptcy proceedings last week, Blumenthal's office reached a deal with Haven officials that turns over control of Haven's finances to an independent restructuring officer.

Starkowski confirmed Monday that there had been discussions between his department and the attorney general's office as far back as June 2006 about placing Haven into receivership, but he disputed that Blumenthal's office had pushed for action to be taken quickly. He said social services officials "had to do due diligence" before going to court to seek a takeover of Haven, and that the attorney general's office understood that.

"If the attorney general and his staff were so concerned about us not pursuing receivership, I never heard those concerns directly" from Blumenthal, Starkowski said.

Starkowski said his agency did not believe a year ago that it had grounds to seek a receiver for Haven - a step he called complex and drastic - because the nursing-home chain was not showing clear signs of financial distress.

"The whole emphasis of receivership is based on imminent financial distress," Starkowski said. "We didn't see evidence of that" until recently.

Haven filed for bankruptcy last month in the wake of a Courant series that detailed the chain's serious patient-care deficiencies and mounting debt problems. In the past three years, Haven has faced the heaviest state fines for health violations of the state's three largest nursing-home chains and has become mired in debt and malpractice litigation.

Blumenthal said lawyers in his office recommended that social services officials pursue receivership because "they believed strongly there were grounds" for it. After the initial recommendation in June 2006, lawyers "went back again and again" with the same advice, he said.

He said he saw no need to call the commissioner directly to reinforce the point because social services officials "know that we make that kind of recommendation only after careful consideration among all the top staff."

Blumenthal said the recommendation was fueled largely by the social services department's April 2006 financial review of Haven, which turned up what he called "rock-solid, shocking evidence of financial improprieties" that his office believed would affect Haven's ability to continue operating.

In that review, James Wietrak, director of the department's audit unit, notified Starkowski that "a large amount" of Haven's funds, obtained mostly from refinancing loans, were being used by Termini to finance "personal investments and business acquisitions."

Wietrak pointed out that Haven officials were using assets to make personal acquisitions instead of installing sprinklers in nursing homes or stabilizing the chain's finances. But his report did not call for drastic action.

"On the surface," Wietrak wrote to Starkowski, "there is nothing that appears to violate any regulations or rate policies, provided that Haven does not include the related party loan costs and refinancing costs" on Medicaid reports filed with the state, which account for how nursing homes spend government money.

The social services agency opted to address the findings by refusing to approve subsequent requests from Haven for discretionary Medicaid increases, while also sharing information about the questionable transactions with other state and federal agencies, officials said.

In the more recent report to Gov. M. Jodi Rell that justified seeking state receivership, Starkowski and department auditors reiterated the findings of the 2006 financial review, which had questioned Termini's use of $5 million in proceeds from a loan secured by Haven Healthcare for the purchase of the Connecticut apartment buildings and a $1.5 million yacht.

Also cited in the 2006 review was a "cash transfer" of $300,000 made to Termini's recording company, Category 5 Records, in November 2005. Haven's chief financial officer, Michael Lipnicki, described that transaction as a "loan" made to Termini and one of his partners, Barry O'Doherty, the report says. The review also describes a $375,000 "wire transfer" of Haven funds to Termini's bank account in January 2006 and a $125,000 wire transfer to O'Doherty's account on the same date.

The audit does not cite the source of funds for the cash transfers. Termini has denied that he diverted government Medicaid or Medicare funds for personal use. In addition to those findings, the more recent report to Rell raised new questions about Termini's diversion of $8.9 million in proceeds from a refinancing loan to Category 5 Records and cited the chain's mounting debt problems.

Although state public health records show that a utility company had threatened to shut off electricity to some Haven homes in January 2006, and a heating oil company had suspended delivery to one home in late 2005, Starkowski said the extent of Haven's financial problems did not become evident until this summer.

"We started to get a preponderance of vendors [seeking payment] this past summer," Starkowski said. A year ago, "I did not have enough information to walk into court on a receivership."

To pursue receivership, the commissioner of social services or public health must petition the court with evidence that a nursing home is in "substantial violation" of the public health code or that it has sustained, or is likely to sustain, a "serious financial loss or failure" that jeopardizes the health and welfare of residents. The court-appointed receiver would take over the home and decide whether to close it, sell it or return it to the owner.

In the past three years, Haven Healthcare has faced a string of state and federal fines for patient-care deficiencies and has been sued by creditors seeking more than $20 million. The state fines included a $100,000 penalty imposed in February against the chain's Waterford home for neglecting a sore on a resident's heel for so long that his leg had to be amputated. Ten Haven homes have been fined multiple times in the past three years for violations that include neglecting residents' fluid or food intake or bedsores.

Termini has acknowledged that a few Haven homes have had significant patient-care problems in the past few years - serious enough that he said he returned to Connecticut full time this summer from Nashville to address them, in part by hiring dozens of new workers. But he has insisted that neither the company's financial troubles nor his own financial dealings ever affected patient care.

Blumenthal has said his office has been pursuing a "whistleblower" investigation into Haven for months. He also has said his office was in contact with federal authorities prior to Nov. 29, when FBI agents and other federal investigators seized documents from the chain's corporate headquarters in an investigation into possible Medicare and Medicaid fraud and tax fraud.

Contact Lisa Chedekel at lchedekel@courant.com.

Copyright © 2008, The Hartford Courant

courant.com/news/custom/topnews/hc-haven0501.artmay01,0,1724936.story

Courant.com

Michigan Company May Buy Haven Nursing Homes

By LISA CHEDEKEL

Courant Staff Writer

May 1, 2008

A Michigan company that operates 21 nursing homes and assisted-living facilities in California and the Midwest is the leading contender to buy the bankrupt Haven Healthcare nursing-home chain — a bid that would preserve all 15 Haven homes in Connecticut, but that is contingent on its ability to secure Medicaid rate increases from the state.

LifeHouse Retirement Properties Inc. has proposed buying Haven's 25 homes in New England for a base price of $105 million, court documents show. All of the proceeds would go to creditors. The company would partner with MatlinPatterson Global Advisors LLC, a private-equity firm that buys up distressed businesses, to finance the Haven purchase.

Under a plan submitted by Haven and its court-appointed restructuring officer, LifeHouse would act as a "stalking horse" bidder at an auction of Haven assets next month, meaning the firm would submit an opening bid designed to set a floor for other prospective buyers. Several other companies have expressed an interest in the chain and remain in contention, Attorney General Richard Blumenthal said.

"As with any auction process, it's difficult to predict, at this point, who will end up with these homes," Blumenthal said. But he said he was encouraged that "there are serious buyers that are making credible offers, and the process [for a sale] is on track."

Haven filed for bankruptcy in November, in the wake of a series in The Courant detailing the chain's financial troubles and repeated citations for patient-care deficiencies. The company defaulted on millions of dollars in bills for supplies and utilities while its chief executive officer, Raymond Termini, used corporate assets to launch a Nashville recording company and make other purchases. Federal authorities have seized corporate records in a continuing investigation into whether Medicare and Medicaid funds were misused.

Termini and some other senior Haven managers would be replaced under the chain's new ownership, but LifeHouse would retain home administrators, nursing staff and other employees, according to lawyers and other officials involved in the sale negotiations.

"I think it's the best possible outcome, under the circumstances," said Alan Kolod, an attorney

representing Haven. "It's good for the patients, for the community and for the employees."

As part of a sale, which is expected in the early summer, Haven and a new owner would have to resolve claims by the state and federal governments for Medicaid or Medicare money that was received by Haven but later deemed a disallowed expense. In a court filing this week, the U.S. attorney's office said the state social services department already had determined that Haven should return more than $2.9 million in Medicaid funds, "not taking into account any civil fraud loss amount which may be determined in the future."

Blumenthal said he expected the state to be able to recoup some Medicaid money from the sale, but was also "vigorously and actively pursuing [other] possible remedies against individuals, including Ray Termini." Termini has staunchly denied any misuse of government funds.

Although 64 entities originally expressed interest in the Haven sale, only 10 submitted proposed purchase prices. Among the other firms that have expressed interest is Formation Capital, which bought out Genesis HealthCare Corp. last year.

LifeHouse's bid is contingent on its ability to secure state Medicaid rate increases, court documents show. David Dearborn, a spokesman for the state Department of Social Services, said agency officials already had begun reviewing Medicaid rate requests submitted by LifeHouse, and would work with the state health department on a close review of LifeHouse's regulatory record and finances.

LifeHouse Chief Operating Officer Lou Andriotti, formerly an executive of the Kindred Healthcare chain, which owns six nursing homes in Connecticut, could not be reached Wednesday for comment.

LifeHouse is a growing company that owns 13 assisted-living facilities and eight nursing homes — 11 in Michigan, two in Illinois and eight in California. Last July, the company bought five Southern California nursing homes, with more than 900 beds, in a bankruptcy auction.

Haven officials said they need to close on a sale by the end of June to comply with a financing arrangement that has allowed the chain to stay afloat. They said in court filings that the chain continues to lose more than $2 million a month. They said they expected the sale proceeds to be sufficient to pay off all of Haven's secured creditors.

The U.S. attorney's office filed an objection to a provision in the LifeHouse agreement that would allow the company to assume Haven's Medicare provider agreements and set aside an escrow fund of $2.5 million to pay off any claims by the government for the return of Medicaid or Medicare funds. The federal attorneys said the escrow fund was inadequate, citing the $2.9 million in Medicaid funds being sought by the state.

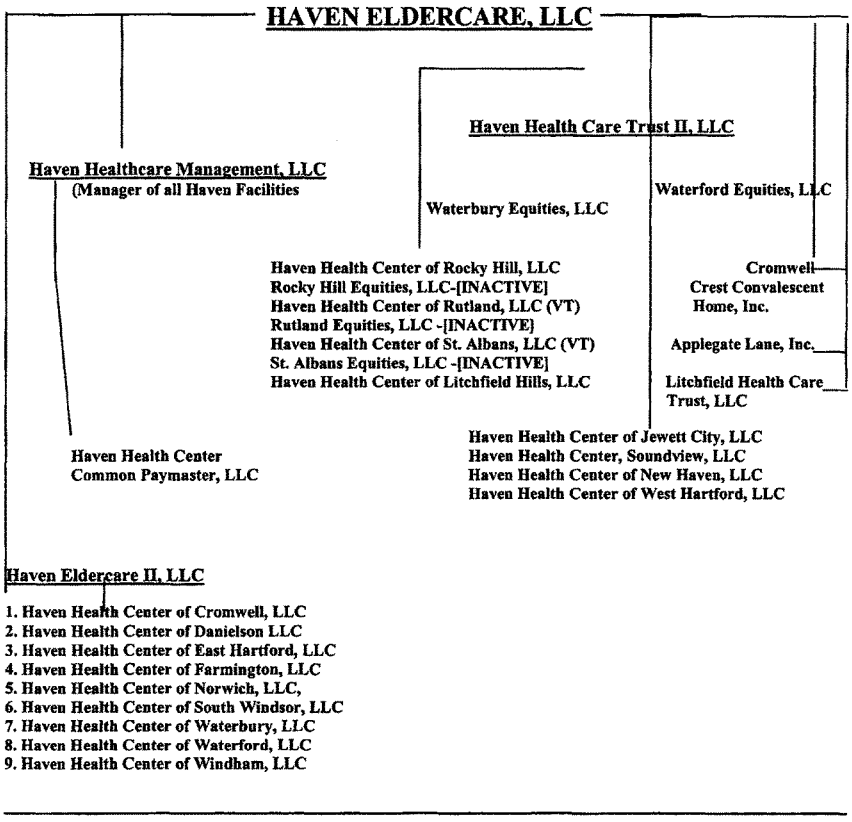
State lawmakers have proposed legislation that would require more detailed financial reporting by nursing-home owners, and more oversight by the state, to head off the kinds of problems that led to Haven's financial collapse.

Contact Lisa Chedekel at lchedekel@courant.com.

Copyright © 2008, The Hartford Courant

HAVEN NURSING FACILITIES AND AFFILIATED ENTITIES ORGANIZATIONAL CHART

(Active Entities)



HAVEN ELDERCARE OF NEW ENGLAND, LLC

Haven Health Center of Warren, LLC (RI)
Haven Equities of Warren, Rhode Island, LLC (RI)
Haven Health Center of Pawtucket, LLC (RI)
Pawtucket Equities, LLC (RI)
Haven Health Center of Greenville, LLC (RI)
Greenville Equities, LLC (RI)
Haven Health Center of Coventry, LLC (RI)
Coventry Equities, LLC (RI)
Haven Health Center of Chelsea, LLC (MA)
Chelsea Equities, LLC (MA)
Haven Health Center at Seacoast, LLC (NH)**
Hampton Equities, LLC (NH)**

**12 ½% of Haven Health Center at Seacoast, LLC and Hampton Equities, LLC are owned as follows: Daniel Trahan: 4.167%; David Trahan: 4.166%; Eileen (Trahan) Piet: 4.167%

HAVEN ELDERCARE OF NEW HAMPSHIRE, LLC

Haven Health Center of Derry, LLC (Stockholder of)
Derry Equities, LLC (INACTIVE]
(Ferretti's Nursing Home, Inc.)
D/B/A Haven Health Center of Derry

HAVEN HEALTH CENTER OF CLAREMONT, LLC

LONG HILL EQUITIES, LLC

245 Long Hill Road Associates, LLC
Scrambler's, LLC

LIGHTHOUSE MEDICAL, LLC

Lighthouse Environmental, LLC
Lighthouse Medical Supply, LLC

Official Form 1 (10/06)

United States Bankruptcy Court

District of Connecticut
New Haven Division

VOLUNTARY PETITION

Name of Debtor - (If individual, enter Last, First, Middle): Haven Eldercare, LLC	**Name of Joint Debtor (Spouse) (Last, First, Middle):** None
All Other Names used by the Debtor in the last 8 years (include married, maiden, and trade names): fka Medway Health Care, LLC	**All Other Names used by the Joint Debtor in the last 8 years (include married, maiden, and trade names):**
Last four digits of Soc. Sec. No./Complete EIN or other Tax I.D. No. (if more than one, state all): 06-1630285	**Last four digits of Soc. Sec. No./Complete EIN or other Tax I.D. No. (if more than one, state all):**
Street Address of Debtor (No. & Street, City, and State): 245 Long Hill Road, Middletown, CT — **Zip Code** 06457-4063	**Street Address of Joint Debtor (No. & Street, City, andvState):** — **Zip Code**
County of Residence or of the Principal Place of Business: Middlesex	**County of Residence or of the Principal Place of Business:**
Mailing Address of Debtor (if different from street address): — **Zip Code**	**Mailing Address of Joint Debtor (if different from street address):** — **Zip Code**
Location of Principal Assets of Business Debtor: (if different from address listed above) — **Zip Code**	

Type of Debtor (Form of Organization) **(Check one box)**

- [ ] Individual (includes joint debtors) *See Exhibit D on page 2 of this form.*
- [x] Corporation (includes LLC and LLP)
- [ ] Partnership
- [ ] Other (If debtor is not one of the above entities, check this box and state type of entity below.)

Nature of Business (Check one box)

- [x] Health Care Business
- [ ] Single Asset Real Estate as defined in 11 U.S.C. § 101 (51B)
- [ ] Railroad
- [ ] Stockbroker
- [ ] Commodity Broker
- [ ] Clearing Bank
- [ ] Other

Tax-Exempt Entity (Check box, if applicable)

- [ ] Debtor is a tax-exempt organization under Title 26 of the United States Code (the Internal Revenue Code).

Chapter of Bankruptcy Code Under Which the Petition is Filed (Check one box)

- [ ] Chapter 7
- [ ] Chapter 9
- [x] Chapter 11
- [ ] Chapter 12
- [ ] Chapter 13
- [ ] Chapter 15 Petition for Recognition of a Foreign Main Proceeding
- [ ] Chapter 15 Petition for Recognition of a Foreign Nonmain Proceeding

Nature of Debts (Check one box)

- [ ] Debts are primarily consumer debts, defined in 11 U.S.C. § 101(8) as "incurred by an individual primarily for a personal, family, or household purpose."
- [x] Debts are primarily business debts.

Chapter 11 Debtors

Check one box:

- [ ] Debtor is a small business as defined in 11 U.S.C. § 101(51D).
- [x] Debtor is not a small business as defined in 11 U.S.C. § 101(51D).

Check if:

- [ ] Debtor's aggregate noncontingent liquidated debts (excluding debts owed to insiders or affiliates) are less than $2 million.

Check all applicable boxes:

- [ ] A plan is being filed with this petition.
- [ ] Acceptances of the plan were solicited prepetition from one or more classes of creditors, in accordance with 11 U.S.C. § 1126(b).

Filing Fee (Check one box)

- [x] Full filing fee attached
- [ ] Filing fee to be paid in installments. (Applicable to individuals only.) Must attach signed application for the court's consideration certifying that the debtor is unable to pay fee except in installments. Rule 1006(b). See Official Form 3A.
- [ ] Filing fee waiver requested (Applicable to chapter 7 individuals only). Must attach signed application for the court's consideration. See Official Form 3B

Statistical/Administrative Information (Estimates only)

- [x] Debtor estimates that funds will be available for distribution to unsecured creditors.
- [ ] Debtor estimates that, after any exempt property is excluded and administrative expenses paid, there will be no funds available for distribution to unsecured creditors.

THIS SPACE FOR COURT USE ONLY

Estimated Number of Creditors	1-49	50-99	100-199	200-999	1,000-5,000	5,001-10,000	10,001 -	25,001-50,000	50,001-100,000	Over 100,000
	[x]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Estimated Assets				
[x] $0 to $10,000	[ ] $10,000 to $100,000	[ ] $100,000 to $1 million	[ ] $1 million to $100 million	[ ] More than $100 million

Estimated Liabilities				
[ ] $0 to $50,000	[ ] $50,000 to $100,000	[ ] $100,000 to $1 million	[x] $1 million to $100 million	[ ] More than $100 million

Voluntary Petition (This page must be completed and filed in every case).	Name of Debtor(s): Haven Eldercare, LLC	
Prior Bankruptcy Case Filed Within Last 8 Years (If more than one, attach additional sheets)		
Location Where Filed: None	Case Number	Date Filed
Pending Bankruptcy Case Filed By Any Spouse, Partner Or Affiliate Of This Debtor (If more than one, attach additional sheet)		
Name of Debtor: See Attached	Case Number: 07-	Date Filed: 20-Nov-07
District	Relationship	Judge

Exhibit A

(To be completed if debtor is required to file periodic reports (e.g., forms 10K and 10Q) with the Securities and Exchange Commission pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 and is requesting relief under chapter 11.)

☐ Exhibit A is attached and made a part of this petition

Exhibit B

(To be completed if debtor is an individual whose debts are primarily consumer debts)

I, the attorney for the petitioner named in the foregoing petition, declare that I have informed the petitioner that [he or she] may proceed under chapter 7, 11, 12, or 13 of title 11, United States Code, and have explained the relief available under each such chapter.

I further certify that I delivered to the debtor the notice required by § 342(b) of the Bankruptcy Code.

X _____
Signature of Attorney for Debtor(s) Date

Exhibit C

Does the debtor own or have possession of any property that poses or is alleged to pose a threat of imminent and identifiable harm to public health or safety?

☐ Yes, and Exhibit C is attached and made part of this petition.

☒ No

Exhibit D

(To be completed by every individual debtor. If a joint petition is filed, each spouse must complete and attach a separate Exhibit D.)

☐ Exhibit D completed and signed by the debtor is attached and made a part of this petition.

If this is a joint petition:

☐ Exhibit D also completed and signed by the joint debtor is attached and made a part of this petition.

Information Regarding the Debtor - Venue

(Check any applicable box)

☐ Debtor has been domiciled or has had a residence, principal place of business, or principal assets in this District for 180 days immediately preceding the date of this petition or for a longer part of such 180 days than in any other District.

☒ There is a bankruptcy case concerning debtor's affiliate, general partner, or partnership pending in this District.

☐ Debtor is a debtor in a foreign proceeding and has its principal place of business or principal assets in the United States in this District, or has no principal place of business or assets in the United States but is a defendant in an action or proceeding [in a federal or state court] in this District, or the interests of the parties will be served in regard to the relief sought in this District.

Statement by a Debtor Who Resides as a Tenant of a Residential Property

Check all applicable boxes

☐ Landlord has a judgment against the debtor for possession of debtor's residence. (If box checked, complete the following.)

_____
(Name of landlord that obtained judgment)

_____
(Address of landlord)

☐ Debtor claims that under applicable nonbankruptcy law, there are circumstances under which the debtor would be permitted to cure the entire monetary default that gave rise to the judgment for possession, after the judgment for possession was entered, and

☐ Debtor has included in this petition the deposit with the court of any rent that would become due during the 30-day period after the filing of this petition.

Prepared using Bankruptcy Plus® by Cornerstone Computer Group Inc., Bellingham, Washington (800) 397-8238

Voluntary Petition
(This page must be completed and filed in every case).

Name of Debtor(s):
Haven Eldercare, LLC

SIGNATURES

Signature(s) of Debtor(s) (Individual/Joint)

I declare under penalty of perjury that the information provided in this petition is true and correct.
[If petitioner is an individual whose debts are primarily consumer debts and has chosen to file under chapter 7] I am aware that I may proceed under chapter 7, 11, 12 and 13 of title 11, United States Code, understand the relief available under each such chapter, and choose to proceed under chapter 7.

[If no attorney represents me and no bankruptcy petition preparer signs the petition] I have obtained and read the notice required by § 342(b) of the Bankruptcy Code.
I request relief in accordance with the chapter of title 11, United States Code, specified in this petition.

X _____
Signature of Debtor

X _____
Signature of Joint Debtor

_____
Telephone Number (If not represented by attorney)

_____
Date

Signature of Attorney

X /s/ Alan Kolod, Esq.
Signature of Attorney for Debtor(s)

Alan Kolod, Esq.
Printed Name of Attorney for Debtor(s)

Moses & Singer
Firm Name

405 Lexington Avenue
New York, NY 10174
Address

(212) 554-7800 — (212) 554-7700
Telephone Number — Fax Number

November 20, 2007
Date

Signature of Debtor (Corporation/Partnership)

I declare under penalty of perjury that the information provided in this petition is true and correct, and that I have been authorized to file this petition on behalf of the debtor.
The debtor requests relief in accordance with the chapter of title 11, United States Code, specified in this petition.

X /s/Raymond S. Termini
Signature of Authorized Individual

Raymond S. Termini
Printed Name of Authorized Individual

CEO
Title of Authorized Individual

November 20, 2007
Date

Signature of a Foreign Representative

I declare under penalty of perjury that the information provided in this petition is true and correct, that I am the foreign representative of a debtor in a foreign proceeding, and that I am authorized to file this petition.

(Check only one box.)

☐ I request relief in accordance with chapter 15 of title 11, United States Code. Certified copies of the documents required by § 1515 of title 11 are attached.

☐ Pursuant to § 1511 of title 11, United States Code, I request relief in accordance with the chapter of title 11 specified in this petition. A certified copy of the order granting recognition of the foreign main proceeding is attached.

X _____
(Signature of Foreign Representative)

_____
(Printed Name of Foreign Representative)

_____
Date

Signature of Non-Attorney Petition Preparer

I declare under penalty of perjury that: 1) I am a bankruptcy petition preparer as defined in 11 U.S.C. § 110, 2) I prepared this document for compensation, and have provided the debtor with a copy of this document and the notices and information required under 11 U.S.C. §§ 110(b), 110(h) and 342(b); and, 3) if rules or guidelines have been promulgated pursuant to 11 U.S.C. § 110 setting a maximum fee for services chargeable by bankruptcy petition preparers, I have given the debtor notice of the maximum amount before preparing any document for filing for a debtor or accepting any fee from the debtor, as required in that section. Official Form 19B is attached.

_____
Printed Name and title, if any, of Bankruptcy Petition Preparer

_____
Social Security Number (If the bankruptcy petition preparer is not an individual, state the Social Security number of the officer, principal, responsible person or partner of the bankruptcy petition preparer) (Required by 11 U.S.C. § 110)

_____
Address

X _____
Signature of Bankruptcy Petition Preparer or officer, principal, responsible person, or partner whose social security number is provided above.

Names and Social Security numbers of all other individuals who prepared or assisted in preparing this document unless the bankruptcy petition preparer is not an individual:

If more than one person prepared this document, attach additional signed sheets conforming to the appropriate official form for each person.

A bankruptcy petition preparer's failure to comply with the provisions of title 11 and the Federal Rules of Bankruptcy Procedure may result in fines or imprisonment or both 11 U.S.C. § 110; 18 U.S.C. § 156.

LIST OF AFFILIATED ENTITIES

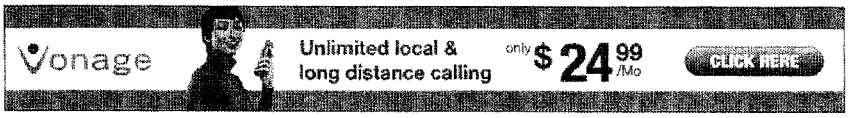
On November 20 and 21, 2007, all of the following affiliated entities filed with this Court separate, voluntary petitions under Chapter 11 of the Bankruptcy Code. Contemporaneously with the filing of those petitions, each of those entities filed a motion requesting that the court jointly administer their Chapter 11 cases.

1. Haven Eldercare, LLC
2. Haven Eldercare II, LLC
3. Haven Health Center of Cromwell, LLC
4. Haven Health Center of Danielson LLC
5. Haven Health Center of East Hartford, LLC
6. Haven Health Center of Farmington, LLC
7. Haven Health Center of Norwich, LLC
8. Haven Health Center of South Windsor, LLC
9. Haven Health Center of Waterbury, LLC
10. Haven Health Center of Waterford, LLC
11. Haven Health Center of Windham, LLC
12. Haven Healthcare Management, LLC
13. Haven Health Center of Rocky Hill, LLC
14. Haven Health Center of Rutland, LLC
15. Haven Health Center of St. Albans, LLC
16. Haven Health Center of Litchfield Hills, LLC, d/b/a Haven Health Center of Torrington
17. Haven Health Care Trust II, LLC
18. Haven Health Center of Jewett City, LLC
19. Haven Health Center, Soundview LLC
20. Haven Health Center of New Haven, LLC
21. Haven Health Center of West Hartford, LLC
22. Haven Eldercare of New England, LLC
23. Waterford Equities, LLC
24. Cromwell Crest Convalescent Home, Inc.
25. Applegate Lane, Inc.
26. Litchfield Health Care Trust, LLC
27. Haven Health Center of Warren, LLC
28. Haven Equities of Warren, Rhode Island, LLC
29. Haven Health Center of Pawtucket, LLC
30. Pawtucket Equities, LLC
31. Haven Health Center of Greenville, LLC
32. Greenville Equities, LLC
33. Haven Health Center of Coventry, LLC
34. Coventry Equities, LLC
35. Haven Health Center of Chelsea, LLC
36. Chelsea Equities, LLC
37. Haven Health Center at Seacoast, LLC
38. Hampton Equities, LLC

39. Haven Eldercare of New Hampshire, LLC
40. Haven Health Center of Derry, LLC
41. Ferretti's Nursing Home, Inc., d/b/a Haven Health Center of Derry
42. Haven Health Center of Claremont, LLC
43. Lighthouse Medical Supply, LLC
44. Haven Health Center Common Paymaster, LLC

courant.com/news/custom/topnews/hrt-tfwhcpoorcare20071117181454,0,3469991.photo

Courant.com



Oscar Aceituno and wife Susana

November 1, 2007

OSCAR ACEITUNO, who has advanced Alzheimer's disease, was placed in a Greenwich nursing home managed by Haven Healthcare after his wife, Susana, became unable to keep track of his wandering. She says that the nursing home neglected to keep watch on him and that he repeatedly wandered away from the facility. On his last venture out, he fell and suffered a serious injury that has kept him confined to a wheelchair. The family has sued Haven, charging negligence.

Copyright © 2008, The Hartford Courant

courant.com/news/politics/hc-nursinghomes0509.artmay09,0,3895659.story

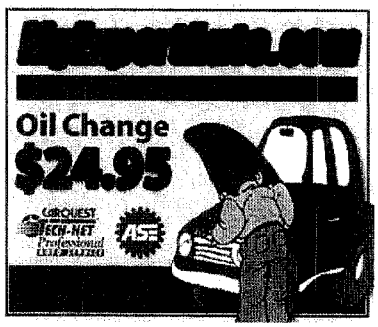
Courant.com

Legislature Left Nursing-Home Reforms On Table

By LISA CHEDEKEL

Courant Staff Writer

May 9, 2008



For months, state Sen. Edith Prague rallied support for nursing-home reforms from Democratic leaders and advocates for the elderly, telling anyone who would listen that "this is the year" for improvements to minimum-staffing requirements and stronger oversight of the industry.

This wasn't the year.

When the legislature adjourned at midnight Wednesday, it left more than a dozen proposals to increase nursing-home staffing levels, enforcement and financial accountability on the table.

"We got nothing. Nothing, nothing, nothing," said Prague, D-Columbia, who has tried for a decade to increase the state's outdated minimum-staffing requirement for nursing homes, which is among the lowest in the country. "This was the closest we've ever come, and it turned out to be a big zero. ... They left everything for the last day, and nothing got done."

Attorney General Richard Blumenthal said he was "deeply disappointed" that lawmakers had not acted on a package of reforms that would have strengthened oversight of nursing homes and allowed the state broader discretion to seek court-appointed receiverships of financially troubled homes. The reforms were prompted by revelations of serious patient care and financial problems at Haven Healthcare, a large chain that declared bankruptcy late last year after a series in The Courant detailed its troubled regulatory record.

"The absence of action is absolutely astonishing, given the experience of the past year and our clear and dramatic experience with the abuses that can result from inadequate oversight," Blumenthal said. "I'm deeply disappointed because the state has essentially been deprived of tools and weapons that are desperately needed to protect both financial assets and patient care."

Democratic legislative leaders blamed the state's tight finances for the lack of action, citing Republican Gov. M. Jodi Rell's warning that she would veto any legislation that carried a significant price tag. Democratic leaders and Rell's office had reached an agreement last week that they would make no changes to the $18.7 billion budget already approved for next year, which provides no increases to nursing homes and nonprofit agencies, and offers lower-than-expected aid for cities and towns.

The "do-nothing" budget deal made no exception for improvements to nursing-home oversight or staffing, even though both Rell and Democratic leaders had touted nursing-home care as a priority.

Among the proposals not acted upon was a bill that would have raised the state's minimum-staffing standard to 3.6 hours of care per resident per day — up from the 1.9-hour requirement now in place.

Federal studies have recommended a minimum of 4.1 hours of care a day.

Because a Democratic proposal to phase in a 3.6-hour minimum would have cost the state $10 million in Medicaid reimbursement in the next fiscal year, Democratic lawmakers late Wednesday pushed the start date ahead to October 2009 to avoid any fiscal impact next year.

But even that proposal died in late-night House debate.

Proposals to make nursing home owners more accountable financially — hashed out in meetings this week — did not get an airing on Wednesday, even though some of them would have had a limited fiscal impact.

Among them was the creation of a state oversight panel that would have had the authority to audit the financial records of nursing homes and related entities, supplementing the role of the state Department of Social Services.

Another would have required the Department of Public Health to publish "report cards" on nursing homes for consumers.

"This is a very sad day for our residents, their families and their caregivers, and an abject failure by the Rell administration and the legislature, who have wasted a rare opportunity to address the crisis of care," said Carmen Boudier, president of the New England Health Care Employees Union, District 1199, which represents nursing-home workers.

She said the death of the staffing bill, "combined with an utter lack of accountability for nursing-home operators and zero funding in this second year of the budget, is a recipe for more nursing home scandals and closures."

Prague said she was discouraged that state House leaders waited until the final hours of the session to raise the staffing bill, then watched it die.

"They all come to the press conferences and say it's a priority, and then they go and leave it until the last day," she said. She said she may ask for nursing-home reforms to be included in the coming special session of the legislature.

House Speaker James Amann, D-Milford, said the staffing proposal was among a number of bills that got pushed to the end of the session, and that Democrats dropped it after Republicans began questioning the fiscal impact in future years.

"We had to pull the plug on a lot of things," Amann said. "The Republicans were filibustering, time was ticking … [and] the governor had that veto threat."

House Republican leader Lawrence Cafero of Norwalk said his members were prepared to talk the staffing bill to death because it imposed higher standards in future years without a way to pay for them.

"It was hypocrisy," he said.

Amann and Senate President Pro Tem Donald E. Williams Jr., D-Brooklyn, said they weren't sure why all the accountability measures fell by the wayside.

"One of the primary reasons was the lack of money," Williams said. "It's unfortunate. It certainly makes sense to have greater control and greater oversight."

Representatives of the nursing-home industry said that although they opposed some provisions of the accountability reforms, they had been braced for the reforms to pass, given the fallout from Haven's collapse.

Haven's CEO used corporate assets to launch a Nashville recording company and buy a lakefront house as millions of dollars in bills for supplies and services to Haven homes went unpaid.

Nursing-home owners also had held out hope that the legislature would approve a 1 percent cost-of-living increase for the state's 240 licensed homes.

Without any increase, "there'll be more bankruptcies, there'll be more receiverships," said Toni Fatone, executive vice president of the Connecticut Association of Health Care Facilities.

Contact Lisa Chedekel at lchedekel@courant.com.

Ethics bill could come up at special session. www.courant .com/capitolwatch

Copyright © 2008, The Hartford Courant

RAYMOND S. TERMINI

78 Louis Drive • Middlefield, CT • (860) 704-8400

EXPERIENCE

Haven Healthcare, Middletown, CT (2000 – present)
Chief Executive Officer

- Owns, operates and manages twenty-four nursing, congregate and Assisted Living Facilities in our New England states, comprised of 2,674 beds with an equal number of dedicated health care professionals.
- Positioned Haven Healthcare to emerge on a regional and national basis as a leader in the healthcare profession.
- Earned a reputation not only as a quality healthcare provider but as a strong patient advocate committed to shaping the future of healthcare policy.
- Formulated and owns Universal Living, LLC that specializes in universal design and home adaptation. Universal Living provides creative solutions and options in an effort to meet the needs of a steadily increasing aging population.
- Formulated and owns Light House Medical, LLC, a company that provides ancillary services to nursing homes which include medical and surgical supplies, pharmacy, housekeeping and laundry.
- Envisioned, innovated, and assisted the American Health Care Association in launching a nationwide grass roots initiative referred to as The Family Alliance for Compassionate Eldercare (FACE). Produced and created a video and anthem for FACE titled "Ray of Light." Introduced FACE to the State Executives from every association in the country in the State Executives meeting at the AHCA annual convention. The Ray of Light Video played in the opening session of the AHCA 53rd annual convention in New Orleans and was viewed by 3500 of the nation's healthcare leadership immediately following the National Anthem. Spoke before the House of Delegates in the closing session of the AHCA convention and was introduced by Dr. Charles Roadman, President & CEO of AHCA as the innovator of FACE. Extended the "Ray of Light Challenge" to mobilize millions of nursing home patient families, friends and staff to speak out on behalf of the nation's frailest elderly to the House of Delegates of AHCA.
- Completing term as Treasurer of the Connecticut Association of Health Care Facilities, Inc.
- **2002:** Secured ~ 38 million in funding and marshaled a three-state, multi-facility mortgage acquisition comprised of in six skilled nursing facilities and an assisted living facility located in Coventry, Warren, Pawtucket and Greenville, RI, Chelsea, MA and Hampton, New Hampshire.
- **2002:** Successfully negotiated a twenty-nine-year operating management agreement, which resulted in the acquisition of a 75-bed skilled nursing facility located in Greenwich, Connecticut. The facility is known today as Haven Health Greenwich. Provided leadership, vision and direction to the facility staff which resulted in the non-Medicaid patient mix shifting from 30% to 40%, overall occupancy shifting from 91% to 96%.
- **2001:** Secured 17 million dollars in funding and marshaled a two-state, multi-facility acquisition comprised of 398 beds in three skilled nursing facilities located in Rocky Hill, Connecticut, Rutland and Saint Albans, Vermont. All are known today as Haven Health Centers of their respective towns or cities.
- **2001:** Successfully negotiated a 30-year operating lease, which resulted in the acquisition of a 128-bed skilled nursing facility located in West Hartford, Connecticut. The facility is known today as Haven Health Center of West Hartford. Provided leadership, vision and direction to the facility staff which resulted in the non-Medicaid patient mix shifting from 20% to 38%, overall occupancy shifting from 75% to 97%. Corrected deficiencies, which totaled 37 State and Federal violations.

EXPERIENCE (Continued)

Haven Healthcare, Cromwell, CT (2000 – Present) (Continued)
Chief Executive Officer

- **2001:** Served on the Board of Directors of the Connecticut Association of Health Care Facilities. Initiated the grass roots initiative with an overall focus on shaping the future of healthcare policy to benefit Connecticut's frailest elderly.
- **2001:** Paved the way for a statewide labor settlement with the New England Health Care Worker District 1199 by sustaining a 23-day labor action involving seven nursing homes and ~ 900 employees. Negotiated the first contract settlement which became a road map and standard for all subsequent contract settlements in the state. Acted as a spokesperson articulating the side of management and appearing on news broadcasts on all four major news outlets eleven times during the job action. Was recognized as an accessible and credible source of information and was quoted in twenty newspaper articles
- **2001:** Successfully negotiated a 30-year operating lease, which resulted in a multi-facility acquisition comprised of ~ 312 beds in three skilled nursing facilities located in New Haven, West Haven and Jewett City, Connecticut. The facilities are known today as Haven Health Centers of their respective towns or cities. Provided leadership, vision and direction to the facility staff, which resulted in the non-Medicaid patient mix shifting from ~ 25% to 38% and overall occupancy shifting from ~ 91% to 95%.
- **2001:** Successfully negotiated a 30-year operating lease, which resulted in the acquisition of a 126-bed skilled nursing facility located in Torrington, Connecticut. The facility is known today as Haven Health Center of Torrington. The facility was in need of renovations and was experiencing census and community perception problems. Within 18 months implemented and managed 1 million dollars in renovations. Provided leadership, vision and direction to facility staff which resulted in the non-Medicaid patient mix shifting from ~ 30% to 40% and overall occupancy shifting from ~ 91% to 96%.
- **2001:** Competed against four Connecticut-based healthcare management companies and won the management contract for one of Connecticut's two municipally operated nursing homes. The facility is known as Smith House Health Center in Stamford, Connecticut. Upon commencement of the management contract the facility was experiencing ~ 75% occupancy and 1.7 million dollars in annual operating losses. Was successful in transforming the facility into a great place to live, visit and work. Increased occupancy to ~ 97 % and completely erased the 1.7 million dollar operating loss.

Roncalli Health Care, Portland CT (1995 – 2000)
Executive Business Manager, Vice President of Operations, Executive Vice President and President

- **2000:** Secured 20 million dollars in funding and marshaled a multi-facility acquisition comprised of 440 beds in three skilled nursing facilities located in Danielson, Windham and Waterford, CT. The facilities are known today as Haven Health Centers of their respective towns or cities. The facilities were in bankruptcy and receivership and in desperate need of change. Within 24 months implemented and managed 5 million dollars in renovations. Provided leadership, vision and direction to facility staff which resulted in the non-Medicaid patient mix shifting from ~ 26% to 35% and overall occupancy shifting from ~ 88% to 95%.
- **1999:** Successfully negotiated a 10-year operating lease, which resulted in the acquisition of a 119-bed skilled nursing facility located in South Windsor, Connecticut. The facility is known today as Haven Health Center of South Windsor. The facility was in need of renovations and was experiencing census and community perception problems. Within 14 months implemented and managed 800 thousand dollars in renovations. Provided leadership, vision and direction to facility staff which resulted in the non-Medicaid patient mix shifting from ~ 21% to 32% and overall occupancy shifting from ~ 88% to 95%.

EXPERIENCE (Continued)

Roncalli Health Care, Portland CT (1995 – 1999) (Continued)
Executive Business Manager, Vice President of Operations, Executive Vice President and President

- **1999:** Successfully negotiated a 30-year operating lease, permanent working capital and 1.3 million in construction funding which resulted in the acquisition of a 140-bed skilled nursing facility located in Farmington, Connecticut. The facility is known today as Haven Health Center of Farmington. The facility was antiquated and outdated. Within 24 months implemented and managed 1.3 million dollars in renovations. Provided leadership, vision and direction to the facility staff which resulted in the non-Medicaid patient mix shifting from 24% to 36% and overall occupancy shifting from ~ 93% to 96%.
- **1998:** Secured 5.7 million dollars in funding and marshaled the acquisition of a 120-bed skilled nursing facility located in Norwich, Connecticut. The facility is known today as Haven Health Center of Norwich. The facility was antiquated and outdated and had recently been unionized. Within 14 months implemented and managed a 2 million dollar renovation project. Provided leadership, vision and direction to the facility staff which resulted in the non-Medicaid patient mix shifting from ~ 18% to 28% and overall occupancy shifting from ~ 91% to 98%.
- **1998:** Secured 4 million dollars in funding and marshaled the acquisition of a 90-bed skilled nursing facility in Waterbury, CT. The facility is known today as Haven Health Center of Waterbury. The facility was in bankruptcy, on the brink of receivership and closure. The facility had 70% overall occupancy, a 1% Medicare population and no private pay patients. The facility had 24 deficiencies with 6 isolated and 3 pattern actual harm citations. Provided leadership, vision and direction and within 16 months the facility underwent 2 million dollars in renovations, JACHO accreditation with commendation, a zero deficiency State survey, ~ 96% occupancy and ~ 30% non-Medicaid patient mix.
- **1996:** Secured 18 million dollars in funding for the refinancing of two 180-bed skilled nursing facilities located in Cromwell and East Hartford, CT. Implemented and managed 6 million dollars in renovations and provided leadership, vision and direction to facility staff which resulted in the non-Medicaid patient mix shifting from ~ 14% to 28% and overall occupancy shifting from ~ 90% to 97%. Was successful deeply rooting a hospitality culture and resident-centered philosophy, which exist throughout Haven Healthcare today.
- **1995:** Developed and implemented a business plan for a banquet and conference center, secured 3 million dollars in funding and managed construction for a full-scale banquet and conference center known today as Saint Clements Castle. The business currently generates revenues in excess of 3 million dollars annually and is recognized as one of Connecticut's premiere banquet and conference centers.

Scramblers Family Style Restaurants (1990 – 1995)
Owner/ President

- Owned and operated three family-styled restaurants which were eventually sold.

East Coast Development Corp (1980 – 1990)
Owner/ President

- Owned and operated a construction and home improvement company which generated 5 million dollars in annual sales.

EDUCATION

Life-long inner work and self-education studying the theories and principals of John P. Kotter, Professor of Leadership at Harvard Business School, Dr. John C. Maxwell and Stephen R. Covey.

INTERESTS

Music is a primary passion. As a song writer, vocalist, bassist, guitarist and pianist, have performed in country music's most prestigious venues.