



Center Statement on Nursing Home Reform for Senate Finance Committee

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PROMOTING ELDER JUSTICE: A CALL FOR REFORM HEARING BEFORE THE U.S. SENATE COMMITTEE ON FINANCE

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I am a Senior Policy Attorney in the Washington, D.C. office of the Center for Medicare Advocacy, a national not-for-profit legal organization that focuses on assuring access to Medicare and high quality health care. I have represented nursing home residents and their interests in Washington, D.C. since 1977 – more than 42 years.

The Inspector General's report last month documented the failure of nursing facilities across the country to report incidents of potential abuse or neglect of residents to their state survey agency in 2016.^[1] Looking at a sample of high-risk emergency room claims submitted by hospitals to Medicare, the Inspector General estimated that 7831 cases of potential abuse or neglect of residents had occurred. That's more than one claim for every two nursing facilities in the country. The Inspector General also found that facilities failed to report more than 84% of these incidents to the state survey agencies, as required by federal law.^[2]

These statistics are appalling, but, unfortunately, they are not surprising to advocates for nursing home residents, who hear every day from residents and their families across the country about the many ways the promise and mandate of the 1987 Nursing Home Reform Law are not being met.

No single action will prevent the abuse and neglect of residents. Multiple approaches are necessary. I offer four approaches that I believe would help reduce abuse and neglect of residents and, more broadly, assure that all residents enjoy high quality of care and high quality of life.

First, unless and until we ensure that all facilities have sufficient numbers of well-trained, well-supervised, and well-compensated nursing staff, abuse and neglect will not be prevented and nursing homes will not provide residents with good care. The key single predictor of good quality of care and quality of life for residents is nurse staffing – both the professional registered nurses and licensed practical nurses and the paraprofessional nursing staff, the certified nurse assistants who provide the majority of direct hands-on care, often for minimum wage salaries. Nursing facilities do not have sufficient nursing staff.

The new payroll-based staffing information that the Centers for Medicare & Medicaid Services (CMS) now collects, as required by the Affordable Care Act, documents that nursing facilities nationwide have too few nursing staff to provide care to an ever-more frail and dependent population of residents. An analysis of these new data, published in a recent *Health Affairs* article, finds that “that “75 percent of nursing homes were almost never in compliance with what CMS expected their RN staffing level to be, based on residents’ acuity.”[3] Since these CMS expectations are based on a report that is nearly 20 years old, a time when residents were less disabled and had fewer care needs than today’s residents, it is indisputable that most facilities today do not have sufficient nursing staff to meet residents’ needs.

The new data also confirm what residents and families have known and told us for years – that facilities overstated their staffing levels under the prior system, have fewer staff on weekends, and boost their staffing in anticipation of surveys.

Unless and until we ensure that all facilities have sufficient numbers of well-trained, well-supervised, and well-compensated nursing staff, nursing homes will not provide residents with good care.

Second, the survey and enforcement systems have failed to ensure that facilities meet federal standards of care and need to be significantly strengthened. Enforcement, now implemented on a facility-by-facility basis, should also evaluate facilities on a corporate-wide basis. The ongoing dismantling of meaningful enforcement needs to be reversed.

Surveys by state survey agencies are unannounced, but predictable. Many surveys are conducted at the same time every year, even though federal law since 1987 has authorized surveys on a nine to 15-month cycle,[4] and more surprise in the timing of surveys is possible. Even more troubling, more than 95% of problems found by surveyors are called “no harm”[5] – with the result that the facility usually faces no penalty. These no-harm deficiencies can include sexual assaults of residents,[6] broken bones,[7] maggots in a resident’s scrotum[8] – all of these problems have been called no harm. The Center recently issued a report about “five star” facilities with no harm deficiencies.[9]

Yet even for the relatively small number of problems that are classified as actual harm or immediate jeopardy, facilities face few penalties.

Since 1987, federal law has required states and the federal government to have a range of sanctions to impose – including federal civil money penalties, denials of payment for new admissions, directed plans of correction, monitors, and termination – and to impose more serious penalties for more serious problems and for problems that are not corrected or that recur over time.^[10]

While enforcement has always been the least implemented part of the Reform Law, enforcement has now come to an almost complete halt. The Trump Administration has changed the enforcement system so dramatically^[11] that nursing facilities face few (if any) or limited consequences, no matter how serious the problems and how poor the care. In the clearest example of the retreat on meaningful enforcement, federal guidance now calls for per instance civil money penalties,^[12] rather than per day civil money penalties,^[13] as required by the Obama Administration.

The average per instance civil money penalty is now less than \$9000.^[14]

A recent administrative appeal involved a nursing facility's failure to assess a resident who experienced a significant change in condition and was in respiratory distress. For more than four hours, staff failed to take the man's vital signs or to call his physician. The facility finally took his vital signs and, an hour later, sent him to the hospital, where he died. Sustaining the deficiencies, which reflected failure to follow nursing standards of practice and the facility's own policies, as well as the federal regulations (all of which were consistent with each other), Administrative Law Judge Steven T. Kessel described the \$10,000 per instance civil money penalty, less than half the maximum amount, as "trivial" for the facility's "egregious" noncompliance.^[15] Judge Kessel noted that per day penalties would have been "many times what CMS determined to impose."

For many years, I have been looking at Special Focus Facilities – the small number of nursing facilities (now 88 nationwide) that states and CMS collectively decide are among the poorest performers – they have many very serious care problems and these problems persisted over a period of many years.^[16] The point of the SFF program is to conduct more intense evaluation of the care that these facilities provide to their residents – two standard surveys a year instead of one – and to impose more significant penalties against them. Special Focus Facilities are expected to correct their problems and to stay in compliance or be terminated from Medicare and Medicaid. I have looked at this program over the years because if the enforcement system is not working effectively against the poorest performing facilities in the country, it cannot possibly be working against more marginal facilities.

Earlier this year, I looked at the 37 Special Focus Facilities that CMS identified as having not improved, as of January 19, 2019.[17] Twenty-eight of the 37 facilities were cited with actual harm or immediate jeopardy deficiencies in 2018, but only nine of the 28 had a CMP imposed against them. The CMP imposed against one Special Focus Facility exceeded \$100,000, but the remaining eight CMPs ranged from \$10,400 to \$53,089 and averaged \$19,616.50. In all instances, the CMPs imposed against the nine facilities were far lower than the CMPs that had been imposed against them before they were identified as Special Focus Facilities. For example, one Colorado facility had a CMP of \$11,267 imposed in June 2018 for 11 deficiencies, including one immediate jeopardy deficiency, but CMPs totaling \$191,732 in July 2017 for 15 deficiencies, including one harm-level deficiency and one immediate jeopardy deficiency.[18]

More recently, I looked at the “graduates” of the SFF program, identified on CMS’s May 2019 list.[19] Six of the 21 graduates were cited with harm and immediate jeopardy deficiencies in 2018.

One of the graduates was cited with three immediate jeopardy deficiencies, one at each of three complaint surveys and each of which resulted in a resident’s death. Since fewer than 2-3% of problems are called immediate jeopardy (more than 95% of problems found by surveyors are called “no harm”),[20] this facility appeared to have serious problems in providing care to its residents.

One immediate jeopardy deficiency was based on the facility’s failure to monitor residents who were known to wander. One resident left the facility without the staff’s knowledge on December 30, 2017 and “was found dead outside an opened exterior kitchen door in sub-zero weather.”[21] Another resident choked to death[22] and a third resident died after falling twice from a broken mechanical lift sling and suffering a brain bleed.[23] CMS did not impose a civil money penalty for any of these deficiencies, but imposed denial of payment for new admissions (of unknown duration), a different remedy, for the choking death.[24]

The facility also had problems with nurse staffing. The federal website did not report staffing levels for the facility. The icon on *Nursing Home Compare* indicates that the facility may not have submitted auditable staffing data or may have reported “a high number of days without a registered nurse.”

The facility’s record in 2018 does not meet the criteria CMS sets for graduation from the Special Focus Facility program – “These nursing homes not only improved, but they sustained significant improvement for about 12 months (through two standard inspections).”[25]

The survey and enforcement systems need to be strengthened to cite deficiencies accurately and to impose appropriate sanctions so that facilities remain in compliance with federal standards of care.

Third, Congress cannot rely solely on public information to improve nursing home quality. Information on the federal website *Nursing Home Compare* needs to be accurate, comprehensive, and transparent, but public information, while important and necessary, is not sufficient. We cannot expect a resident – for example, an 85-year old widow with dementia who cannot speak and has multiple physical and medical conditions and no family in the area – to use the information to choose a facility or monitor her own care or complain to an ombudsman or the state survey agency.

A market-based approach to regulating nursing homes cannot be the sole approach to ensuring quality. The Nursing Home Reform Law describes the Secretary's "duty and responsibility . . . to assure that the federal standards of care, and their enforcement, are adequate to protect residents' health, safety, welfare, and rights" and to "promote the effective and efficient use of public moneys."^[26] Federal law mandates appropriate substantive standards, effectively enforced.

Finally, states must establish and enforce meaningful standards for who is eligible to operate a facility (i.e., receive a state license) and, independently, CMS must establish and enforce meaningful standards for who is eligible to receive Medicare and Medicaid reimbursement for care (i.e., receive federal certification). At present, ownership and management of nursing facilities, often divided among multiple companies,^[27] appear to shift with little public information and insufficient public oversight.

The collapse of Skyline Healthcare last year was the most visible and vivid example of the problem of allowing companies without adequate financial and management resources to take over facilities. On July 19, 2019, *NBC Nightly News* broadcast an investigative report on Skyline, its collapse, and the impact on residents and their families.^[28] This New Jersey company had a handful of facilities, but then, beginning in about 2016 or 2017, began to manage facilities across the country, primarily facilities that large chains, including Golden Living and Manor Care, decided not to operate any longer. In a period of little more than a year, Skyline Healthcare began operating between 100 and 120 facilities in eight states across the country. Then, within a similarly short period, it stopped meeting payroll and paying vendors.^[29] States went to court to get authority to take over the facilities – the legal term is receivership – in order to make sure that residents received care, food, medicine, and supplies.

While other companies had gone into bankruptcy before and other owners had abandoned facilities before, there had never been such a large collapse, affecting so many states, so many facilities, and so many residents and staff. Skyline's collapse brought attention to the problem of who owns and who manages facilities – and whether are they qualified and competent to do so.

The *Philadelphia Inquirer* describes changes in the nursing home industry that led to this crisis for residents, families, communities, and states:

The nursing home industry in recent years has been engulfed in wholesale changes in operators as Golden Living and other large companies, often under regulatory and financial pressure, abandon the business and lease bunches of facilities over to firms that emerge from nowhere.^[30]

States and CMS cannot allow “firms that emerge from nowhere” to operate nursing facilities. Meaningful standards of ownership and management are critical and these standards must be effectively enforced.

Not all facilities provide poor care, of course, but too many do. Preventing abuse and neglect of residents and improving quality of care and quality of life in nursing facilities for all residents require multiple efforts, simultaneously made – improving staffing, strengthening survey and enforcement processes, and making sure that individuals and companies that own and manage nursing facilities are prepared and competent to provide good care. Residents and their families and taxpayers deserve no less.

[1] Office of Inspector General, *Incidents of Potential Abuse and Neglect of Skilled Nursing Facilities Were Not Always Reported and Investigated*, A-01-16-00509 (Jun. 2019), <https://oig.hhs.gov/oas/reports/region1/11600509.pdf>.

[2] 42 C.F.R. §483.12(c)(1). The facility must report abuse or incidents involving serious bodily injury immediately, but not less than 2 hours after the allegation is made, to the administrator and the state survey agency. The facility must report other incidents within 24 hours. 42 C.F.R. §483.12(c)(1). The facility must thoroughly investigate incidents, 42 C.F.R. §§483.12(b)(2), 483.12(c)(2), and report the results of the investigation, within 5 days, to the administrator and state survey agency officials, 42 C.F.R. §483.12(c)(4).

[3] Fangli Geng, David G. Stevenson, and David C. Grabowski, “Daily Nursing Home Staffing Levels Highly Variable, Often Below CMS Expectations,” *Health Affairs* 38, N. 7 (2019): 195-1100.

[4] 42 U.S.C. §§1395i-3(g)(2)(A)(iii)(I), 1396r(g)(2)(A)(iii)(I), Medicare and Medicaid, respectively.

[5] CMS, *Nursing Home Data Compendium 2015 Edition*, Figure 2.2.e. Percentage Distribution of Scope and Severity of Health Deficiencies: United States, 2014, p. 48 (showing 0.9% of deficiencies as immediate jeopardy; 2.3% of deficiencies as actual harm), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/nursinghomedatacompendium_508-2015.pdf.

[6] <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=235705&SURVEYDATE=09/06/2018&INSPTYPE=STD> (Sep. 6, 2018 standard survey, Helen Newberry Joy Hospital LTCU, Michigan).

[7] <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=055750&SURVEYDATE=10/31/2017&INSPTYPE=CMPL> (Oct. 31, 2017 complaint survey, Amberwood Gardens, California).

[8] <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=145736&SURVEYDATE=10/31/2017&INSPTYPE=CMPL> (Oct. 31, 2017 complaint survey, Alden Town Manor Rehab & HCC, Illinois).

[9] "Elder Justice, What 'No Harm' Really Means for Residents," Vol. 2, Issue 2, <https://www.medicareadvocacy.org/wp-content/uploads/2019/06/Elder-Justice-Newsletter-Vol-2-No-2.pdf>.

[10] 42 U.S.C. §§1395i-3(h), 1396r(h), Medicare and Medicaid, respectively.

[11] Jordan Rau, "Trump Administration Eases Nursing Home Fines in Victory for Industry," *The New York Times* (Dec. 24, 2017), <https://www.nytimes.com/2017/12/24/business/trump-administration-nursing-home-penalties.html?searchResultPosition=1>; Toby S. Edelman, "Deregulating Nursing Homes," *Bifocal* (publication of the American Bar Association Commission on Law and Aging), Vol. 39, Issue 3 (Dec. 4, 2018), https://www.americanbar.org/groups/law_aging/publications/bifocal/vol-39/issue-3-february-2018-/DeregulatingNursingHomes/.

[12] CMS, "Final Revised Policies Regarding the Immediate Imposition of Federal Remedies," QSO 18-18-NH (Jun. 15, 2018), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-18-NH.pdf> (making final CMS, "Revised Policies regarding the Immediate Imposition of Federal Remedies – FOR Action," S&C: 18-01-NH (Oct. 27, 2017), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-01.pdf>).

[13] CMS, "Mandatory Immediate Imposition of Federal Remedies and Assessment Factors Used to Determine the Seriousness of Deficiencies for Nursing Homes," S&C: 16-31-NH (Jul. 22, 2016, revised Jul. 29, 2016), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-31.pdf>.

[14] Jordan Rau, Kaiser Health News, "Trump Administration Cuts The Size Of Fines For Health Violations In Nursing Homes," National Public Radio (Mar. 15, 2019), <https://www.npr.org/sections/health-shots/2019/03/15/702645465/trump-administration-cuts-the-size-of-fines-for-health-violations-in-nursing-hom>.

[15] *St. John of God Retirement and Care Center v. CMS*, DAB CR5290 (Apr. 12, 2019), <https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2019/alj-cr5290/index.html>.

[16] CMS, "Special Focus Facility ("SFF") Initiative, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/SFFList.pdf>.

[17] "There's Nothing Special About How CMS Treats Special Focus Nursing Facilities" (CMA Alert, Feb. 14, 2019), <https://www.medicareadvocacy.org/theres-nothing-special-about-how-cms-treats-special-focus-nursing-facilities/>. The full report is at <https://www.medicareadvocacy.org/report-theres-nothing-special-about-how-cms-treats-special-focus-nursing-facilities/>.

[18]

<https://www.medicare.gov/nursinghomecompare/profile.html#profTab=5&ID=065248&state=CO&lat=0&lng=0&name=BETHANY%2520NURSING%2520%2526%2520REHAB%2520CENTER&Distn=0.0> (listing CMPs). June 28, 2018 immediate jeopardy supervision deficiency, standard survey, at

<https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=065248&SURVEYDATE=06/28/2018&INSPTYPE=CMPL> (pp. 28-36); July 18, 2017 complaint survey, sexual harassment, at

<https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=065248&SURVEYDATE=07/18/2017&INSPTYPE=CMPL> (pp. 1-9).

[19] "Special Report – 'Graduates' from the Special Focus Facility Program Provide Poor Care" (CMA Alert, Jun. 20, 2019), <https://www.medicareadvocacy.org/graduates-from-the-special-focus-facility-program-provided-poor-care/>.

[20] CMS, *Nursing Home Data Compendium 2015 Edition*, Figure 2.2.e. Percentage Distribution of Scope and Severity of Health Deficiencies: United States, 2014, p. 48 (showing 0.9% of deficiencies as immediate jeopardy; 2.3% of deficiencies as actual harm),

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/nursinghomedatacompendium_508-2015.pdf.

[21] <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=145924&SURVEYDATE=01/09/2018&INSPTYPE=CMPL>. pp. 1-4 (Jan. 9, 2018 complaint survey, Champaign Rehab Center, Illinois).

[22] <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=145924&SURVEYDATE=03/06/2018&INSPTYPE=CMPL>. pp. 1-3 (Mar. 6, 2018 complaint survey, Champaign Rehab Center, Illinois).

[23] <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=145924&SURVEYDATE=03/28/2018&INSPTYPE=CMPL>. pp. 1-5 (Mar. 28, 2018 complaint survey, Champaign Rehab Center, Illinois).

[24]

<https://www.medicare.gov/nursinghomecompare/profile.html#profTab=0&ID=145924&state=IL&lat=0&lng=0&name=CHAMPAIGN%2520REHAB%2520CENTER&Distn=0.0> (site visited Jul. 19, 2019).

[25] CMS, Special Focus Facility ("SFF) Program (updated Jun. 27, 2019), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/SFFList.pdf>.

[26] 42 U.S.C. §§1395i-3(f), 1396r(f)(1), Medicare and Medicaid, respectively.

[27] Joseph E. Casson, Julia McMillen, "Protecting Nursing Home Companies: Limiting Liability through Corporate Restructuring," *Journal of Health Law*, Vol. 36, No. 4 (Fall 2003).

[28] "NBC News Investigation: Nursing home chain collapses amid allegations of unpaid bills, poor care" (Jul. 19, 2019), <https://www.nbcnews.com/nightly-news/video/nbc-news-investigation-nursing-home-chain-collapses-amid-allegations-of-unpaid-bills-poor-care->

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