S. HRG. 99-1082
VOL. 1

NURSING HOME CARE: THE UNFINISHED AGENDA (Volume I)

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

WASHINGTON, DC

MAY 21, 1986

Serial No. 99-19

Printed for the use of the Special Committee on Aging

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NURSING HOME CARE: THE UNFINISHED AGENDA

WEDNESDAY, MAY 21, 1986

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

The committee convened, pursuant to notice, at 9:10 a.m., in room SD-628, Dirksen Senate Office Building, Hon. John Heinz (chairman) presiding.

Present: Senators Heinz, Glenn, Pryor, Chiles, Cohen, Grassley, Pressler, Bingaman, Nickles, and Wilson.

Staff present: Stephen McConnell, staff director; Robin Kropf, chief clerk; Isabelle Claxton, communications director; Sara White, assistant communications director; Jim Michie, chief investigator; David Schulke, investigator; David Cunningham, investigator; Diane Lifsey, minority staff director; Bill Benson, minority professional staff member; Kimberly Kasberg, hearing clerk; Diane Linskey, staff assistant; and Dan Tuite, printing assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ

Chairman HEINZ. Ladies and gentlemen, the committee will come to order.

Good morning. It was about 12 years ago that this committee, the Special Committee on Aging, released a report of its investigation into nursing home care in the United States. The conclusions of that report were quite alarming, with over 50 percent of the homes in the country cited for abuses ranging from untrained or inadequate staff, negligence leading to death or injury, lack of control of drugs, unsanitary conditions, and poor food.

Today the committee is releasing a second report, which I have here and which has been provided, I think, to all the members of the press, with the findings of a 2-year staff investigation of the current status of care in the Nation's some 15,000 federally certified nursing homes.

Frankly, the news, after all these years, is still grim.

Now, to be fair, some homes do provide quality care. Many homes provide adequate care. Indeed, take the two together, quality care and adequate care, maybe as many as two-thirds of the nursing homes in this country provide either adequate or quality care. But for a substantial number of homes which we have looked at, what we have seen is that we have allowed bed, board, and abuse to replace the medical and rehabilitative care that the law demands.

We have warehoused tens of thousands of our oldest, sickest citizens, and the Federal Government is not doing anything about it.

Facilities participating under the Medicare and Medicaid Programs must comply under the law with certain conditions of participation and undergo annual inspections to prove that they continue to, quote, "substantially," unquote, meet these conditions.

Now, there is always argument about what conditions are important and which ones are unimportant. Well, the Aging Committee staff analyzed inspection reports for some 8,852 skilled nursing facilities for the years 1982 to 1985. We have over 1,100 feet of computer printouts of violations—more than 200 feet a year. And we were only evaluating performance—and this is the most important point—on the 25 most critical conditions out of some 541—just the 25 most important out of 541.

Our data shows that more than one-third of these facilities, about 3,000, failed to meet at least 1 of those 25 basic conditions—25 of the most important of the 541—in 1984. Over 1,000 homes failed to meet three or more such conditions. A substantial number of these homes, around 600 of them, are not only grossly inadequate, but they are chronic offenders, violating not only three or more conditions, but doing so at least three out of four inspections.

Most indicative of the backslide in quality care in nursing homes today are the dramatic percentage increases in the number of violations of the most critical life-sustaining conditions.

This chart here shows nine critical components of critical standards. We found a 75-percent increase in citations for lack of adequate physician supervision. That is No. 4 there. It went from 73 to 128, a 75-percent increase. We found a 61-percent increase in facilities failing to provide adequate 24-hour nursing care, and this is in a skilled nursing facility.

And dropping down just two more, we found a 92-percent increase in the failure of facilities to meet patients' nutrition and feeding needs; and a 75-percent increase, going up to the third from the top, a 75-percent increase in patients subjected to mental, physical, and/or chemical—that is to say, drug—abuse.

Now, we may have brought buildings up to code. We may have brought about daily cleaning of the hallways. We may have drinking fountains now up to regulation height. But we have at this point failed, I think somewhat dismally, to assure a decent level of patient care.

Recent reports from the Inspector General of the Department of Health and Human Services and by the Institute of Medicine reinforce the findings of this committee. In testimony submitted for this hearing, the Inspector General of the Department of Health and Human Services states that—and I quote, "Failure of nursing homes to meet Federal conditions of participation are not uncommon," unquote. He goes on to say, quote, that, "Substandard homes can remain in the [Medicare and Medicaid] Programs for years, while providing less than adequate care to patients."

And the Institute of Medicine's report finds that 10 to 15 percent of homes with chronic problems remain in the program, if you will, yo-yoing back and forth, in and out of compliance.

These studies and their statistics cannot begin to paint a full picture of endless hours spent strapped in a wheelchair, on a diet of

tranquilizers. They do not help the patient whose heart fails in the early hours with no nurse or doctor on call to restore life. But they do—they do—send a clear message to Congress and this administration that we must act and strengthen inspections, enforce penalties, and put the care of the patients first before another year goes by, let alone another 12 years.

We have a very full panel of witnesses today, and I look forward to their testimony, but first I want to call on our ranking member of this committee, Senator John Glenn.

STATEMENT BY SENATOR JOHN GLENN

Senator GLENN. Thank you, Mr. Chairman.

Let me start out by saying that it gives me very little pleasure to participate in this hearing today to examine the ongoing quality of care problems in our Nation's nursing homes.

The Aging Committee has a lengthy history of recommending legislative, regulatory, and administrative reforms to ensure adequate care for older Americans who reside in nursing homes.

Many of our recommendations have in fact become law. That is encouraging. But the discouraging part is that, too often, the laws we pass on this issue are not carried out. That is why it is necessary for us to be here once again today addressing these things. Many of the laws have not been carried out, and we are here addressing the "unfinished agenda." Too many of our reforms merely sit on the books. This was the case in past administrations; it was the case in the Carter administration, and unfortunately it is the case, in the Reagan administration, I believe, to an even greater degree. In fact, opposition to the Reagan administration's actions led to a study by the Institute of Medicine, published this past February, which concludes that there is a clear need for a stronger and improved Federal role in the regulation of nursing home care.

It is unfortunate that the Secretary of the Department of Health and Human Services, Dr. Otis Bowen, did not accept our invitation to appear at today's hearing. I was eager to hear Dr. Bowen's thoughts on how we can improve conditions, correct abuses, and improve the effectiveness of Federal enforcement and oversight—and on how we can even just carry out existing law, where we have had law on the books for several years and do not even have the regulations yet to carry them out. In some cases, several years have passed without putting the regulations on the books. The regulations that we wanted written would be out there and in effect.

I am very hopeful that Dr. William Roper, Administrator of the Health Care Financing Administration, who is here, will help end the inordinate delays in implementing the laws that we pass—such as those dealing with the intermediate sanction, authorized by Congress in 1980; the protection of patient funds, based on the 1977 Medicare and Medicaid antifraud and abuse amendments; and the issuance of a list of services telling us exactly what we are buying in nursing homes with Federal Medicaid dollars.

Dr. Roper has been on the job just a couple of weeks, so he is new, and this I believe is his first hearing—is that correct, Doctor?

Dr. ROPER. Yes, sir.

Senator GLENN. We welcome you here, and we are sorry to put you on the pan this morning, but that is the nature of the job that you are in.

While many nursing homes across the Nation, as the chairman said, meet the Federal standards and provide good, tender, loving care, the kind of care you want for any one of your own relatives who may go into one of these homes, far too many fail to meet minimum Federal requirements essential to the health, safety, and welfare of their patients.

I had a personal experience with this within the past 60 days, when a member of my family who was in the hospital, and then had to go into a nursing home in another city—not in Ohio, I would add, and I will not say the city. I went to—I think it was six—different nursing homes to see the conditions that I wanted the family member to have when they got out of the hospital. I was rather appalled. The nursing homes I went into in that major city ran the whole gamut, from absolutely disgusting to excellent, to wonderful. Fortunately, we were able to get my family member into one of those better-type homes. But I would not have wanted to see the person in at least a couple of those places that I visited that day.

I look forward to today's testimony about the actions that must be taken to improve access to quality care—actions such as considering expansion of "swing-beds" prohibiting discrimination against patients who must rely on Medicaid or who are considered "heavy care," strengthening Federal patients' rights and the Nation's system of nursing home ombudsmen, and improving the Federal enforcement system.

My home State of Ohio has adopted a number of important initiatives, including a tough anti-Medicaid-discrimination statute, a patient-oriented reimbursement system, and a strong patients' rights law. And some of the other States have taken initiatives on their own, also not willing to wait while the Federal Government got moving in this area. I am certain that the Federal Government could benefit from studying these and other State-level accomplishments around our country.

Mr. Chairman, I share your concern about the continued failure of the Federal regulatory system to ensure good care and respect for the rights of nursing home patients. These tax dollars used in this way come from all of us, all over this country, and we expect those dollars to be administered to do the job for the intended purpose.

I look forward to continuing to work together to pursue needed legislative and administrative changes on behalf of our Nation's more than 1 million older Americans who live in nursing homes.

Mr. Chairman, that is an abbreviated version of a lengthier opening statement that I would ask unanimous consent be included in the record.

Chairman HEINZ. Senator Glenn, without objection your entire statement will appear in the record.

[The prepared statement of Senator Glenn follows:]

STATEMENT OF SENATOR JOHN GLENN
AT A HEARING BEFORE THE
U.S. SENATE SPECIAL COMMITTEE ON AGING
"NURSING HOME CARE: THE UNFINISHED AGENDA"
MAY 21, 1986

Mr. Chairman, as the Ranking Democratic Member of the Senate Special Committee on Aging, I must state that it gives me little pleasure to participate in this hearing to examine the on-going quality of care problems in our nation's nursing homes. Like you, I am concerned about the continued failure of the federal regulatory system to ensure good care and respect for the rights of nursing home patients.

It is important to state that there are many nursing homes across the nation that consistently meet federal standards and provide decent care to their elderly and disabled patients. Others exceed these standards and provide exemplary care and services to their residents. Yet, as today's testimony and the written hearing record will clearly demonstrate, far too many nursing homes continue to fail to meet minimum federal requirements essential to the health, safety and welfare of their patients. These facilities, despite the identification of serious deficiencies by federal and state inspectors, continue to receive federal funds from the Medicaid and Medicare programs, while providing inadequate care.

As Members of the Senate Special Committee on Aging, we can take pride in the Committee's track record in identifying serious quality of care problems associated with nursing homes. We have a long-standing record of bringing to light major policy concerns and recommending legislative, regulatory and administrative reforms to ensure an adequate level of care and respect for the rights and dignity of frail, ill and vulnerable older Americans who reside in nursing homes.

The Aging Committee set the pace for protecting nursing home patients with its 1974 landmark hearings and series of reports entitled "Nursing Home Care in the United States: Failure in Public Policy." Some twenty months ago, in October 1984, we conducted an in-depth hearing on "Discrimination Against the Poor and Disabled in Nursing Homes." Many of the issues raised then are with us today. Most recently, we held a series of hearings addressing quality of care issues associated

with Medicare's Prospective Payment System (PPS) and learned of serious access and quality problems pertaining to nursing home care. At those hearings, we put forward a number of major recommendations designed to improve quality and access to care, including S. 2331, the "Medicare Quality Protection Act of 1986."

A number of our recommendations have become law and are now on the books. And that's why we are here today addressing the "unfinished agenda" -- it appears that too many of our reforms merely sit on the books. Too often, the Administration has failed to carry out the laws we pass on this issue. These problems, however, are not unique to the Reagan Administration. Protection of nursing home residents is not a partisan issue. Several Administrations have been castigated by this Committee over their failure to protect both patients and taxpayers. Today, we will hear about Smith v. Heckler -- the most important nursing home litigation to date -- originally filed in 1975 by a group of Colorado nursing home patients. Nearly ten years later, after a decade of little action by successive Administrations, the 10th Circuit Court of Appeals ruled, in a landmark decision, that the federal government has a duty to ensure "high-quality medical care."

Unfortunately, this Administration seems determined to turn its back on elderly nursing home patients to a degree that we have never before encountered. The Reagan Administration has repeatedly expressed its intent to reduce the federal role in protecting patients in federally-financed nursing homes. Hopefully, the ruling of the 10th Circuit Court will help to reverse this trend.

At the close of the Carter Administration, the Department of Health and Human Services issued a new rule elevating patients' rights to a Medicare and Medicaid Condition of Participation. The Reagan Administration revoked it within days of assuming office and then proposed to effectively deregulate the nursing home industry in 1982. Consumer and public opposition was so great that this proposal was scrapped, only to be followed by a proposal to reduce the federal role in oversight of nursing homes. Tremendous Congressional and consumer opposition resulted in a Health Care Financing Administration (HCFA)-financed study by the Institute of Medicine (IOM). The final report, issued this past February, concludes that there is a clear need for a stronger and improved federal role in the regulation of nursing home care.

I am pleased that our hearing follows the IoM report and its constructive recommendations, many of which this Committee has previously endorsed. I am optimistic that action will be taken due to Congressional, consumer and public awareness. Public concern, coupled with the work of our Committee and many Members of Congress, the growing network of nursing home ombudsmen, the IoM report and other activities have ensured

considerable momentum to bring about needed reforms. An important addition to this momentum is the responsible reaction from leaders in the nursing home industry who have endorsed the IoM report.

Now, it is time for the Administration to join us in our effort. I regret that the Secretary of the Department of Health and Human Services, Dr. Otis Bowen, did not accept the invitation to appear at today's hearing. I looked forward to hearing Dr. Bowen's thoughts on how we can improve conditions, correct abuses and improve the effectiveness of the federal enforcement and oversight responsibilities, and his agenda for resolving the problems that will be raised today.

I am anxious to move beyond the inordinate delays that we have experienced in getting HCFA to implement the laws that we pass. I hope that Dr. William Roper, the newly appointed Administrator of HCFA, will assure us of a new responsiveness at HCFA. As an example, I hope that HCFA will soon issue final regulations for implementing the intermediate sanction which Congress authorized in 1980. Our staff met with HCFA three times regarding the draft regulations issued in February 1985 to make substantive recommendations for improving them. They are important and need to be finalized promptly. Mr. Chairman, you and I wrote to the Administration asking them to promulgate rules regarding the protection of patient funds, which OMB had quashed despite our enactment of the 1977 Medicare and Medicaid Anti-Fraud and Abuse Amendments. That same law requires the Secretary to issue a list of services covered by Medicaid. Despite our efforts, that list has never been published. We still do not know exactly what we are buying in nursing homes with federal Medicaid dollars.

Today's other witnesses, including family members who will share with us their personal experiences with the shortcomings of the nursing home regulatory system, will provide us with an even clearer picture of the inadequacies that must be overcome. This hearing will demonstrate the need to examine the artificial distinctions in our levels of care, and the need to improve access to quality care -- by considering expansion of "swing-beds" and by prohibiting discrimination against patients who must rely on Medicaid or who are considered "heavy care." We will also discuss strengthening federal patients' rights and the nation's system of nursing home ombudsmen; improving the federal enforcement system; and giving states adequate support, including a range of alternative sanctions, to carry out their federally-mandated responsibilities. Finally, as testimony today will indicate, HCFA must effectively gather, analyze and put to use the data it has at its disposal to identify and deal with chronically substandard homes.

Many states have successfully implemented significant reforms to address nursing home problems. The federal government can learn from these efforts and adapt them to ensure

that all Medicare and Medicaid beneficiaries benefit from similar protections. My home state of Ohio has adopted a number of important initiatives, including a tough anti-Medicaid discrimination statute, a patient-oriented reimbursement system and a strong patients' rights law. I am certain that HCFA could benefit from studying these and other state-level accomplishments.

Mr. Chairman, I look forward to joining you and other members of the Committee in pursuing needed legislative and administrative changes on behalf of the nation's more than one million older Americans who live in nursing homes, as well as the millions of taxpayers who pay to ensure adequate care and quality.

I appreciate the participation of today's witnesses. What each of you has to say will not only help to increase public awareness about these issues, but will assist us in pursuing legislative and administrative remedies to these very serious problems. I welcome your comments today and the discussion that will follow.

-30-

Chairman HEINZ. Let me just say for the record that this committee does follow the "early bird" rule, except for the chairman, and the next Senator I will recognize under that rule is Senator Pryor of Arkansas who, I have to say, was working on nursing homes back when he was a House Member in 1970 and 1971. He became famous for holding a cookout at a local abandoned gas station because there was no room for the House Select Committee on Aging, which he tried to form. And he even went up to Honesdale, PA, on one occasion, in fact, in those dark days, and he has been a real crusader and pioneer in this area.

David, I imagine you feel a little bit like Senator Glenn, which is that revisiting this issue gives you no pleasure.

Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman.

Senator GLENN. Excuse me, Mr. Chairman. If I could just have 5 seconds, I have some other commitments this morning, and I will be in and out during the hearing; but I will be reading all the testimony and may want to submit additional questions when it is over.

Chairman HEINZ. Without objection, Senator Glenn.

Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman, and I appreciate those very kind remarks.

I have a longer statement I would like to submit for the record, and I will just use two or three thoughts at this time.

Chairman HEINZ. Without objection, so ordered.

STATEMENT BY SENATOR DAVID PRYOR

Senator PRYOR. I would like to first say, Mr. Chairman and my colleagues, that this is not a very happy day. This is in fact a very depressing moment, I think, for our country.

We look at the number of violations that we see growing at a very rapid rate, and I must be honest with you, until the last several days I had been led to believe as most Americans that things were getting much better and not getting worse. But it appears that we are not going uphill, we are going downhill. And it is for that reason that I am extremely concerned, and I must say extremely depressed about it.

We see all of these violations, and it appears that the increases in these violations are growing at a very rapid rate. I think that we face a dilemma in our country. What do we do, what sanctions do we impose? I think that is one of the things that this committee must consider. I think that is one thing that we have to recommend.

We know for a fact that over 1.5 million American citizens now reside in nursing homes. That number is going to double over the next several years. And the dilemma as to sanctions and how we police this industry—and it is an industry—that dilemma is going to become even greater and more important.

Mr. Chairman, I am very proud that you have had this study commissioned, and once again I look forward to trying to find some solutions, because I think all of us care, and I think all of us are going to be seeking an answer.

I would at this time like to ask unanimous consent that my statement be submitted for the record.

Thank you, Mr. Chairman.

Chairman HEINZ. Senator Pryor, without objection, so ordered.

[The prepared statement of Senator Pryor follows:]

OPENING STATEMENT

SENATOR DAVID PRYOR

before the

U.S. SENATE SPECIAL COMMITTEE ON AGING

at a hearing on

NURSING HOME CARE: THE UNFINISHED AGENDA

9 a.m., Room 628 Wednesday

Dirksen Senate Building May 21, 1986

Mr. Chairman, I am pleased to be here today as the Special Committee on Aging continues its inquiry into nursing home care in the United States. This Committee has had a long-standing interest in the issue of quality care for nursing home residents, dating back to the days when Senator Frank Moss and Val Halamandaris performed their very valuable investigations into nursing home care throughout the country. My own personal interest in this issue began almost two decades ago during my tenure in the House of Representatives, shortly after the establishment of the Medicare and Medicaid programs. I might add that this interest was spurred by the concerns of one of my most vocal constituents, my mother.

Only 1.4 million senior citizens reside in long term care institutions in this country (about 5 percent of the total population), but over the next 20 years that number will almost

double. And the proportion of old old among that population -- the most infirm of our elderly -- will continue to grow. Nursing home care remains the single most reliable source of care for these dependent people, and billions of federal and state dollars (in addition to out-of-pocket expenditures) are spent with the expectation that quality nursing home care is being provided. Yet this is not necessarily the case, as the Committee's investigation should reveal today.

Mr. Chairman, I contend that even if less than one percent of the elderly population were institutionalized that quality care in these institutions should be among our nation's highest priorities. Our effectiveness as a nation should be measured by our ability to provide for those among us who are the most vulnerable, regardless of the size of that population. When I conducted my nursing home investigations back in the early 1970's, I found a deplorable situation in nursing homes. Since that time much has changed. Nursing home residents groups and concerned relatives groups have sprung up throughout the nation, national coalitions have become much more vocal about the needs of residents, and the Congress has worked (particularly over the last five years) tirelessly to prohibit the watering down of certification standards. Yet, for those facilities which are chronically out of compliance with federal regulations, conditions remain much like those that I saw years ago. This

situation translates into untold human suffering, and the greatest tragedy of it all is that it should be avoidable.

Mr. Chairman, we all have a responsibility to ensure that adequate, quality care is given to nursing home residents. In coming months the Congress will be wrestling with issues related to the severe nursing home bed shortage, long term care insurance, expansion of incentives for facilities to participate in the Medicare program, hospital swing beds, national prospective rates for nursing home care, geriatric nursing home training, and others. Throughout our discussions we must do our best to ensure that quality care is provided at the most appropriate service level. We must also do our best to see that the problems associated with the Department of Health and Human Services new regulatory efforts are corrected. The Department is to be commended for redirecting survey and certification efforts toward the quality of care patients are actually receiving. However, the National Citizens Coalition for Nursing Home Reform and the Institute of Medicine study have confirmed the widespread concerns about:

-the implementation schedule;

-training guidelines and training follow-up;

-the provision for updates of surveyor guidelines;

-appropriate allocation of reimbursement resources; and

-the degree of public participatin in the survey process.

Mr. Chairman, these areas must be addressed adequately before we will be ready to move on to the other issues on the long term care agenda which I mentioned earlier. I want to thank you again for your timely scheduling of this hearing, and commend you for your efforts in this area. I look forward to today's testimony.

Chairman HEINZ. Senator Chiles, former chairman of this committee, who I expect feels like he is having a second version of the same thing as well, a deja vu.

STATEMENT BY SENATOR LAWTON CHILES

Senator CHILES. Mr. Chairman, you are right, and I know the kind of concern that you have had and that all the members of the committee have had on this subject. I know what our colleague Senator Pryor is speaking about, because I know that as a Member of the House, he did an awful lot of work over there on nursing homes and trying to expose the problems that were there. And we thought that between the House and the Senate we had set some things in motion that would make this better.

I also know, Mr. Chairman, that over the last few years when we have tried to ask the administration, tried to talk about the fact that we saw that there were reduced numbers of inspections, also that there were reduced numbers of checks and certifications,[1] and we were told, "Not to worry. We have just changed our procedure. We are able to do this by a better method. We do not have to physically be there all the time. We have other monitoring processes that are doing this," and they assured us "everything is getting better." I have that same sort of feeling that everyone is expressing here. Finding, I guess, that those things which we feared the worst have actually come to pass and are actually out there. Finding that again we are talking about the people that cannot care for themselves, the ones that have no advocates and that cannot speak for themselves, and finding that these folks have not had the kind of care and attention that they deserve. It is a terrible indictment.

I think there is no more important subject that we could be dealing with. I am sorry that we are here dealing with this subject, but on the other hand, thank goodness we now have some information before us, maybe we can get about the task of trying to remedy the problems that are out there.

Chairman HEINZ. Senator Chiles, thank you very much.

Senator Cohen was also very active in concerns involving aging as a Member of the House and has been one of the most active members of this committee, together with the Senator sitting to his right, Senator Chuck Grassley of Iowa.

Bill.

STATEMENT BY SENATOR WILLIAM S. COHEN

Senator COHEN. I have a very brief statement that I would like to submit for the record. I do not want to deprive our witness of his first opportunity to present some testimony before the committee.

I would like to offer a couple of comments. I heard some of our colleagues have made comments pointing the finger of blame at the Reagan administration. I would suggest that the problem goes back a lot further in time and indeed cannot be pointed to any one administration, Republican or Democrat. Both have been guilty, in my judgment, of a lack of either concern or initiative in this particular field.

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[1] See volume II, appendix 6, pp. 1, 67, 73, 87, 184, 283, 343-364, 372-378, 381, 383, 441, 467, and 481.

I also think that Congress, this panel even bears some measure of responsibility. On the one hand, we pass laws designed to create or deal with one set of problems only to create a different set of problems. For example, we were concerned about rising hospital costs, so we devised a new prospective payment scheme to try and rein-in the cost of hospital care for Medicare beneficiaries. So we passed this new legislation, and we indeed were successful in reining the hospital costs, only to create another set of problems by giving incentive to hospitals to shift the patients out and put them into nursing homes.

Of course, then the problem becomes one of a shortage of beds, giving the nursing homes undue leverage over who they are going to care for and how that care is going to be delivered.

There has also been another problem, and that is a lack of an effective enforcement mechanism for existing nursing home standards and regulations. We are either forced to shut down a nursing home that is in violation, thereby throwing the patients out into the street, or allowing the home to continue with the existing abuses. So we have not had very effective enforcement as well.

And, as noted before, Congress bears some measure of responsibility. Back in 1973, one of the first measures that Senator Heinz and I introduced in the House of Representatives was a nursing home patients' bill of rights. It did not go anywhere. It was introduced again in the 94th and the 95th Congresses and again in the Senate in 1979. Since that time, most of the provisions of that nursing home patients' bill of rights have been put into effect by way of regulation, but, as the staff study reveals, those regulations have not been very effectively enforced.

I recently reintroduced patients' rights legislation, the Long-Term Care Residents' Rights Act. Hopefully, we can enact this bill into law; but even so there is only one evil greater, it seems to me, than not having enough laws on the books: That is having laws on the books which go unenforced. This is the crux of the problem we are facing today. There are existing laws and regulations but they are not being effectively enforced. I am hopeful that through this hearing, Mr. Chairman, and your leadership, we will find a way to effectively enforce those laws.

Chairman HEINZ. Senator Cohen, thank you very much.

[The prepared statement of Senator Cohen follows:]

OPENING STATEMENT OF

SENATOR WILLIAM S. COHEN

before the

SPECIAL COMMITTEE ON AGING

MAY 21, 1986

MR. CHAIRMAN, I want to commend you for calling this hearing today to examine the issue of quality of care in nursing homes.

In the 1970s both Congress and the general public were shocked by studies revealing appallingly bad care in nursing homes in most parts of country. While it is generally agreed that conditions in nursing homes have improved since then, it is clear that there is much that can be done to ensure that all nursing home patients have access to quality care.

The results of the Aging Committee staff's investigation are re-enforced by the Institute of Medicine's long-awaited report on the quality of care in nursing homes released earlier this year. The Institute of Medicine's study concluded that, while the disturbing practices noted previously occur less frequently, serious problems of abuse

and neglect continue to exist. The study found that in many government-certified nursing homes, "individuals who are admitted receive very inadequate -- sometimes shockingly deficient -- care that is likely to hasten the deterioration of their physical, mental, and emotional health. They also are likely to have their rights ignored or violated, and may even be subject to physical abuse."

The protection of "patients' rights" in long-term care facilities has long been one of my primary concerns. I first introduced legislation to guarantee the basic civil and human rights of nursing home patients in 1973, when I was a Member of the House of Representatives. I reintroduced similar legislation in the House in both the 94th and 95th Congresses, and again upon coming to the Senate in 1979. While many of the "rights" delineated in these early bills have been incorporated into the regulations governing long-term care facilities participating in medicare and medicaid, enforcement of these regulations has been woefully inadequate. Therefore, in February of this year I introduced the "Long-Term Care Residents' Rights Act," which would set in law a national standard of rights and basic guarantees to compassionate care for residents of nursing homes.

We are all appalled by reports of abuse and neglect of nursing home patients, and action must certainly be taken to ensure their health and safety. However, I believe that we

should also be appalled by the accounts of patients being treated with disrespect -- of patients being viewed as incapable of making choices about things as simple as what to wear, when to wake up, and who to see. Far too often these decisions are made for the convenience of the facility, not for the comfort of the patients. While problems related to "patients' rights" in nursing homes may, at first glance, seem less urgent than outright abuse or neglect, I believe that they are intrinsically related to the quality of care issue in that they are essential to quality of life. Quality health care encompasses not simply medical treatment, but also a basic understanding and respect for the patient as an individual and a human being. This is particularly important given the fact that for many long-term care patients, the nursing home is both a permanent and final residence.

Chairman HEINZ. Senator Chuck Grassley.

STATEMENT BY SENATOR CHARLES E. GRASSLEY

Senator GRASSLEY. Yes; I think—taking off from where Senator Cohen just finished—I think it is clear that we do need an improvement in performance standards, in inspections and in enforcement. And of course, we need this at a time that as the graying of America continues, there is little doubt that the long-term-care component of our health care system is going to become an increasingly important one to increasing numbers of Americans falling in that category.

Now, despite progress toward this goal, there are still problems in the deliverance of long-term-care. In many States, there is a shortage of nursing beds. The incentives in Medicare's prospective payment system have increased the pressure on the availability of beds, people being put out of hospitals quicker and consequently, sicker.

Studies have also shown that Medicaid-eligible elderly are suffering disproportionately from the lack of access to nursing home beds when private pay and patients with lower needs are accepted in lieu of needy Medicare elderly.

Another concern that I have, Mr. Chairman, is the number of nursing homes that are chronically found out of compliance with the minimum quality standards, and yet they continue to operate; and of course, certainly, the influx of heavier care patients and limited Medicare reimbursement have made the provision of care more difficult for the nursing homes.

However, we need to examine the performance of the Health Care Financing Administration, and this hearing is doing that, in regard to how effectively they are monitoring compliance with health and safety standards. And of course, we all recognize that HCFA has taken steps to improve its database to deal with the repeat offenders in the long-term care system and to reform its survey process. Yet it appears that HCFA needs to more clearly provide guidance and assistance to States—and particularly I feel this way about my State of Iowa—in interpreting its quality regulations.

Congress, of course, as Senator Cohen said, can help by putting some teeth into the enforcement mechanism by providing authority for HCFA to employ intermediate sanctions or penalties short of cutting off all Federal funds.

So there are many different aspects of this, and I am sure this oversight hearing and the work of this committee will bring it out so that we can have a more clear direction.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES E. GRASSLEY

Mr. Chairman, I appreciate the opportunity to participate in this hearing this morning. I would first like to take just a moment to welcome our first witness, the new Administrator of the Health Care Financing Administration, Dr. William Roper. Congratulations, Dr. Roper, on your recent Senate confirmation and I look forward to working with you through my committee memberships on this committee, the Finance Committee and Labor and Human Resources Committee.

Mr. Chairman, as the "graying" of America continues, there is little doubt that the long-term care component of our health care system will become an increasingly

important one. Now during the last 15 years, we have experienced an improvement in nursing home care and regulation. I think it is clear, however, that improvement is needed in the areas of performance standards, inspection, and enforcement. Congress needs to continue to work toward assurance that the 1.5 million residents in our Nation's 15,000 nursing homes are receiving high quality care.

Despite progress toward this goal, there are still problems in the deliverance of long-term care. In many States, a shortage of nursing beds exist and finding a nursing home bed that offers quality care is difficult. The incentives in Medicare's perspective payment system have increased the pressure on availability of beds, as patients are being released from our hospitals quicker and sicker. Studies have also shown that Medicaid-eligible elderly are suffering disproportionately from lack of access to nursing home beds, when private pay and patients with lower needs are accepted in lieu of needy Medicare elderly.

Another concern is the number of nursing homes that are chronically found out of compliance with minimum quality standards, yet continue to operate. Certainly, the influx of heavier care patients and limited Medicare reimbursement have made the provision of care more difficult for nursing homes. However, we need to examine the performance of the Health Care Financing Administration in effectively monitoring compliance with health and safety standards. I recognize that HCFA has taken steps to improve its data base to deal with repeat offenders in the long-term care system and to reform its survey process. Yet it appears that HCFA needs to more clearly provide guidance and assistance to States in interpreting its quality regulations. Congress, as well, can help put teeth into enforcement mechanisms by providing authority for HCFA to employ intermediate sanctions or penalties, short of cutting off all Federal funds.

Mr. Chairman, we recognize that the population in our nursing homes is a vulnerable one. I am hopeful that our hearing this morning can provide us direction to better ensure that our nursing home residents receive appropriate care, are treated with dignity and continue to enjoy their legal and civil rights.

Chairman HEINZ. Senator Grassley, thank you very much.

Senator Pressler.

STATEMENT BY SENATOR LARRY PRESSLER

Senator PRESSLER. Well, I thank you very much, and I shall submit an opening statement for the record. I just want to say that it is my feeling that in my home State of South Dakota, we do not have so much of a problem in that we have very dedicated employees in nursing homes. However, maybe we have more of a problem than I think. So I think it is very appropriate for us to be looking into this subject. I will submit a written statement for an opening statement.

Chairman HEINZ. Very well. Thank you very much, Senator Pressler. Without objection, so ordered.

[The prepared statement of Senator Pressler follows:]

STATEMENT OF SENATOR LARRY PRESSLER

BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

NURSING HOME CARE: UNFINISHED AGENDA

WEDNESDAY, MAY 21, 1986

LET ME BEGIN BY THANKING THE CHAIRMAN FOR HOLDING THIS HEARING ON NURSING HOME CARE. I HAVE BEEN ACTIVELY INVOLVED IN SENIOR CITIZENS' ISSUES SINCE FIRST COMING TO CONGRESS, AND THE QUALITY OF CARE IN OUR NURSING HOMES CONSISTENTLY TOPS THE LISTS OF PRIORITIES FOR THOSE INVOLVED IN AGING CONCERNS. I HOPE THE TESTIMONY SHARED HERE TODAY WILL SHED NEW LIGHT ON THE PROBLEM OF SUBSTANDARD CARE, AND LEAD TO REFORMS IN THIS AREA.

THE CARE OUR NATION'S ELDERLY RECEIVE IN NURSING HOMES, THE SUBJECT OF TODAY'S HEARING, AND IS POSSIBLY ONE OF THE MOST IMPORTANT SUBJECTS THAT WILL BE EXAMINED BY THIS COMMITTEE. THE ELDERLY POPULATION IS GROWING EVERY YEAR IN THE UNITED STATES DUE TO ADVANCES IN MEDICAL TECHNOLOGY. PEOPLE ARE LIVING LONGER AND THE NEED FOR NURSING HOMES IS INCREASING. THIS NEED, HOWEVER, MUST BE MET IN THE MOST CONSCIENTIOUS MANNER. THE ELDERLY IN THESE NURSING HOMES ARE NOT JUST A CATEGORIZED SECTOR OF OUR SOCIETY, BUT OUR GRANDPARENTS, PARENTS, AUNTS, UNCLES, AND OTHER RELATIVES. THEY ARE OUR LOVED ONES WHO DESERVE THE BEST POSSIBLE CARE AVAILABLE.

THE SENATE COMMITTEE ON AGING STAFF REPORT HAS PRODUCED SOME VERY EYE-OPENING STATISTICS REGARDING THE NUMBER OF SUBSTANDARD SKILLED NURSING FACILITIES IN OUR COUNTRY. AS WE HEAR TESTIMONY

FROM THE TWO DISTINGUISHED PANELS OF WITNESSES, I HOPE WE CAN ALL GAIN A BETTER PERSPECTIVE ON THE PROBLEM OF NURSING HOMES WHICH ARE NOT MEETING CRITICAL HEALTH AND QUALITY OF CARE STANDARDS. THE ENFORCEMENT OF FEDERAL STANDARDS MUST BE GIVEN PRIORITY BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. THE FASTEST GROWING SECTOR OF THE POPULATION IS THAT OF PEOPLE BETWEEN THE AGES OF 60 AND 80 YEARS. THIS TREND WILL FURTHER INCREASE THE NEED FOR NURSING HOMES IN TODAY'S SOCIETY AND MAGNIFY STATE AND FEDERAL GOVERNMENT'S RESPONSIBILITY IN REGULATING THESE FACILITIES AND IN ENFORCING THOSE REGULATIONS.

IN ADDITION, WE MUST FOCUS UPON THE REASONS NURSING HOMES ARE DEFICIENT IN MEETING CRITICAL CARE STANDARDS. THE IMPACT OF THE IMPLEMENTATION OF THE PROSPECTIVE PAYMENT SYSTEM HAS LARGELY CONTRIBUTED TO THE GREATER DEMAND FOR COMPLEX CARE, AND A GREATER NEED FOR NURSING HOMES TO PROVIDE THIS CARE. SHORTER HOSPITAL STAYS HAVE RESULTED IN CROWDED NURSING HOMES FOR RECUPERATION AND PROFESSIONAL CARE. CONGRESS, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE HEALTH CARE FINANCING ADMINISTRATION, AND STATE OFFICIALS MUST WORK TOGETHER TO PROVIDE THE BEST CARE POSSIBLE FOR THOSE ELDERLY CITIZENS IN NURSING HOMES.

AGAIN, I WOULD LIKE TO THANK THE CHAIRMAN FOR HOLDING A HEARING ON THE VITAL ISSUE OF NURSING HOME CARE, AND I LOOK FORWARD TO HEARING THE TESTIMONY OF THE KNOWLEDGEABLE WITNESSES ASSEMBLED HERE TODAY.

Chairman HEINZ. Well, Dr. Roper, you are the new, brand new, squeaky-clean new, Administrator of the Health Care Financing Administration. Of all the people in this half-circle up here, you are one person who cannot yet be part of the problem. [Laughter.]

And I do think I speak for the entire committee that we have great expectations, Dr. Roper, as you take hold of the reins of the agency most responsible for the health care of older Americans. I think we all know, too, that running an agency with so many programs, and they are so critical to the well-being of the elderly and the poor of this Nation, that is going to be no easy task.

So we welcome you here today, and this committee does indeed look forward to working with you in your new capacity. When you were confirmed by the Finance Committee a few weeks ago and you and I visited, little did you or I know that your first official visitation to the Hill would be in this capacity.

So we very much appreciate your being here, and we look forward to hearing your views.

If you do summarize your statement, let me assure you your full statement will be made a part of the record.

Please proceed.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Dr. ROPER. Thank you, sir.

Mr. Chairman, members of the committee, I am Bill Roper, Administrator of the Health Care Financing Administration. I am pleased to have the opportunity to meet with you today and to discuss our contributions to the overall agenda to assure the health, safety, and rights of Medicare and Medicaid beneficiaries in nursing home facilities.

As Senator Heinz has just said, I am personally interested in this subject. He and I talked about my commitment as a physician to quality of care, and Secretary Bowen has done the same. I am glad to be here today.

I have gained a great deal of experience with nursing homes with issues concerning quality of care, and with cooperation between States and the Federal Government during my years as a local and State health official in Alabama. I believe that experience will serve me well in my tenure as Administrator of HCFA when dealing with the issue of nursing home regulation.

The quality of care in nursing homes in America has improved significantly since the original survey and certification monitoring system was first implemented for Medicare and Medicaid in 1974. Today, with the help and cooperation of the States, we are able to use a number of tools to monitor skilled nursing facilities providing care to both Medicare and Medicaid beneficiaries and intermediate care facilities for Medicaid recipients, and to correct problems which directly affect the well-being of those elderly and disabled recipients.

The President, Secretary Bowen and I are fundamentally committed to ensuring quality of care in Medicare and Medicaid. Bene-

ficiaries of these programs and their families rightfully expect that of us.

We think we have a sound and effective program, but we realize that in any program there are always additional improvements that can be made.

I want to share with you today our current monitoring efforts and our planned future activities to strive for the best care in nursing homes for all Medicare and Medicaid beneficiaries.

Before I get into that, I just want to say I am glad that this is my first hearing, Senator Heinz. And if I can share with you a personal note, about a year ago, my mother died after a 10-year illness with Alzheimer disease. The last year of her life she spent in a nursing home. So I bring to this issue not only professional concern, but personal as well.

HCFA contracts with States to inspect or survey to determine if a nursing home facility meets the Federal conditions of participation and standards. This is referred to as the survey and certification process.

State agency personnel perform initial surveys and periodic resurveys of nursing homes at least annually. Surveyors make additional unannounced visits between regular visits to determine the status of a previously identified problem or to investigate complaints.

Identified problems result either in the facility submitting a written plan of correction or, if there are more serious problems, our terminating it from the Medicare and/or Medicaid Programs.

Termination is the last resort, but we will not hesitate to exercise that authority to terminate facilities. In fact, last year 130 skilled nursing facilities and 108 intermediate care facilities were terminated from participation under the Medicare and Medicaid Programs.[2]

We are working aggressively to improve this process further. We implemented revised termination procedures [3] last December with the States to expedite the termination of substandard nursing homes.

These new procedures accelerate the process for terminating facilities with intermediate and serious threat situations. We are beginning to see the effects of these termination procedures already on all segments of the nursing home systems. Beneficiaries have added assurance that they will get quality care in that facility, or they will be relocated to another facility.

I was in touch yesterday with my colleagues in the Alabama Department of Public Health and talked with them about their enforcement of these new termination instructions, and they say this has made a real step forward in the process.

HCFA conducts Federal onsite surveys through our regional offices of a sample of all types of facilities to determine the extent that State survey agencies accurately identify facility deficiencies. It is referred to as look behind.

During fiscal year 1985, we performed 464 of these look behind surveys, and this year, we plan to complete 800 of them. Next year

[2] Staff note: decertified facilities were counted twice if they were certified as ICF and as SNF.
[3] See, volume II, appendix 6, p. 630.

the budget calls for continued aggressive use of the authority, with resurveys heavily targeted at facilities that have a pattern of noncompliance.[4]

I assure you that our record in this area of look behind resurveys has made our commitment to enforcement quite clear to those who might think otherwise.

But the current survey process focuses on physical plant and written policies to determine quality of care in nursing homes. Beginning in 1982, the Department began developing a modified survey process that would focus on the actual care given, rather than on process requirements. The result of this new work is a survey tool, a new tool, which is commonly referred to as the patient care and services or PACS tool. The final regulation implementing PACS should be published in the very near future.[5]

PACS has two key features. First, it is a resident-centered approach which provides a more valid estimate of the quality of care furnished by the facilities. It brings the surveyors face to face with the residents of nursing homes. It is not simply a paper audit.

And, second, PACS requires surveyors to follow specific procedures and to review according to a specified checklist, thereby achieving greater consistency in survey methods and findings. It focuses especially on the care that is given, on the nutrition and on the meals that patients receive, and on the drugs that are administered and how they are administered in nursing homes.

Much of the PACS effort has been made possible by the full cooperation of consumer advocates, the nursing home industry, and representatives of State governments. That gives us confidence that we have indeed taken a major step toward improving our assessment of nursing home care.

If a State survey agency determines that a SNF or ICF providing care to Medicaid and Medicare beneficiaries did not comply with one or more of the conditions of participation or standards, the only sanction available to HCFA or the State Medicaid agency is to terminate the facility's provider agreement. Under final regulations, which should be issued in the very near future, HCFA and the States will have an alternative to terminating Medicare and Medicaid provider agreements with facilities found to be out of compliance.[6]

In facilities that have deficiencies which do not pose immediate jeopardy to the health and safety of patients, HCFA and State Medicaid agencies will have the option of either terminating the facility's provider agreement or exercising an intermediate sanction. This intermediate sanction would deny payment for new admissions for a period of up to 11 months while the deficiencies are being corrected.

If a nursing home which has been levied this intermediate sanction remains out of compliance at the end of the period, the Secretary will begin termination procedures immediately.

Even though we feel we do a good job in addressing problems and complaints about nursing home care as they are identified, we

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[4] "Please see appendix 1, testimony of the General Accounting Office."
[5] "Please see Federal Register, June 13, 1986, page 21550."
[6] "Please see Federal Register, July 3, 1986, page 24484."

know the system is not perfect. Both monitoring of nursing homes and coverage of such care for Medicare and Medicaid recipients need continuing examination and improvement.

Beginning in 1983, we funded a study conducted by the Institute of Medicine to look at the full range of nursing home regulatory and enforcement issues and to provide recommendations for changes in the system. This study, which cost $1.6 million, was completed in March, and HCFA has begun a careful review of the study's comments and recommendations.[7] We feel that a report with such scope and complexity deserves an equally thorough review by the Department before responding to the study's recommendations.

I assure you that the Secretary and I will fully examine these issues and make decisions in the best interests of those we serve.

Finally, Mr. Chairman, we are fully committed to protecting our elderly and sick who reside in nursing homes. I think this commitment is clearly evidenced by the work we have already done, but more importantly by the fact that we are continuing to seek improvements in both our requirements and in our enforcement systems.

Let me again mention that I look forward to working with you individually and with the committee and with the Congress in general to further improve these programs. This is an important time in the evolution of care for the residents in nursing homes. I have indicated our commitment to resolving problems, and we will strive to assure that nothing less than quality care is provided to all those residents.

I would be pleased to answer your questions.

Chairman HEINZ. Dr. Roper, thank you very much.

[The prepared statement of Dr. Roper follows:]

[7] "Please see volume II, appendix 6, HCFA memorandum dated 9/5/86; see also related memorandum from the Administration on Aging, dated 7/10/86."

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

WILLIAM L. ROPER, M.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

MAY 21, 1986

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I AM WILLIAM L. ROPER, ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION. I WOULD LIKE TO THANK YOU FOR THIS OPPORTUNITY TO DISCUSS OUR CONTRIBUTIONS TO THE AGENDA TO ASSURE THE HEALTH, SAFETY, AND RIGHTS OF MEDICARE AND MEDICAID BENEFICIARIES IN NURSING HOME FACILITIES. THE INDIVIDUALS IN NURSING HOMES GENERALLY SUFFER FROM ANY OF A NUMBER OF PHYSICAL, FUNCTIONAL, AND MENTAL DISABILITIES; THEY MOST ASSUREDLY DESERVE THE FULL PROTECTION OF THE FEDERAL GOVERNMENT.

THE QUALITY OF CARE PROVIDED IN NURSING HOMES HAS IMPROVED OVER THE PAST DECADE SINCE THE ORIGINAL SURVEY AND MONITORING SYSTEM WAS FIRST IMPLEMENTED FOR MEDICARE AND MEDICAID. THE CURRENT SURVEY SYSTEM, WHICH HAS BEEN IN EFFECT SINCE 1974, WAS IMPLEMENTED TO ADDRESS THE MANY SHORTCOMINGS IN NURSING HOME CARE THAT BECAME EVIDENT IN THE LATE 1960S AND EARLY 1970S. TODAY, WITH THE HELP AND COOPERATION OF THE STATES, WE ARE ABLE TO USE A NUMBER OF TOOLS TO MONITOR SKILLED NURSING FACILITIES (SNFS) PROVIDING CARE TO BOTH MEDICARE AND MEDICAID BENEFICIARIES AND INTERMEDIATE CARE FACILITIES (ICFS) FOR MEDICAID RECIPIENTS, AND TO CORRECT PROBLEMS WHICH DIRECTLY AFFECT THE WELL-BEING OF THOSE ELDERLY AND DISABLED RESIDENTS.

WE FEEL THAT THE CURRENT SYSTEM FOR ASSURING QUALITY CARE IN NURSING HOMES HAS BEEN SUCCESSFUL IN ENSURING APPROPRIATE CARE IN A SAFE ENVIRONMENT. ALTHOUGH WE HAVE HAD A HIGH DEGREE

OF SUCCESS, I WOULD BE THE FIRST TO ADMIT THAT WE ARE NOT PERFECT. HCFA IS RESPONSIBLE FOR CARE IN ALMOST 50,000 HEALTH CARE FACILITIES IN THE UNITED STATES, OF WHICH ABOUT 20,000 ARE NURSING HOMES PROVIDING CARE TO MORE THAN 1.75 MILLION MEDICARE AND MEDICAID RECIPIENTS. WITH SO MANY FACILITIES PROVIDING CARE TO SO MANY PERSONS, IT IS INEVITABLE THAT ISOLATED INCIDENCES OF SUBSTANDARD CARE WILL OCCUR. OF COURSE, WHEN WE LEARN OF THESE CASES WE REACT IMMEDIATELY AND WILL NEVER BE SATISFIED UNTIL THERE ARE NO SUCH INSTANCES.

WE THINK WE HAVE A SOUND AND EFFECTIVE PROGRAM, BUT WE REALIZE THAT IN ANY PROGRAM THERE ARE ALWAYS ADDITIONAL IMPROVEMENTS THAT CAN BE MADE. I WOULD LIKE TO SHARE WITH YOU TODAY OUR CURRENT MONITORING EFFORTS AND FUTURE ACTIVITY TO STRIVE FOR THE BEST CARE IN NURSING HOMES FOR ALL MEDICARE AND MEDICAID BENEFICIARIES.

CURRENT ACTIVITIES

STATE AND FEDERAL SURVEYS

TO ASSURE THAT HIGH QUALITY CARE IS AFFORDED MEDICARE AND MEDICAID BENEFICIARIES, WE WORK WITH THE STATES TO ENFORCE FEDERAL CONDITIONS OF PARTICIPATION (FOR SNFS) AND STANDARDS (FOR ICFS). HCFA CONTRACTS WITH STATES TO INSPECT, OR SURVEY, TO DETERMINE IF A NURSING HOME FACILITY MEETS THE FEDERAL CONDITIONS OF PARTICIPATION AND STANDARDS.

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THE PROCESS FOLLOWED BY STATE SURVEY AGENCIES IS REFERRED TO AS THE "SURVEY AND CERTIFICATION PROCESS." THIS PROCESS IS ESTABLISHED BY LAW, IMPLEMENTED AND ENFORCED BY REGULATIONS, AND INTERPRETED IN PROCEDURAL REQUIREMENTS THAT MUST BE FOLLOWED BY THE STATE AND FEDERAL AGENCIES INVOLVED IN THE SURVEY AND CERTIFICATION PROCESS.

STATE AGENCY PERSONNEL PERFORM INITIAL SURVEYS AND PERIODIC RESURVEYS OF NURSING HOMES AT LEAST ANNUALLY. THESE SURVEYS:

- ASSESS THE EXTENT AND DEGREE TO WHICH EACH FACILITY IS IN COMPLIANCE WITH THE REGULATORY REQUIREMENTS; AND
- OBTAIN AN OVERALL EVALUATION OF A FACILITY'S PERFORMANCE AND EFFECTIVENESS IN RENDERING APPROPRIATE AND SAFE PATIENT CARE.

SURVEYORS MAY MAKE ADDITIONAL UNANNOUNCED VISITS BETWEEN REGULAR VISITS TO DETERMINE THE STATUS OF A PREVIOUSLY IDENTIFIED PROBLEM OR TO INVESTIGATE COMPLAINTS. IDENTIFIED PROBLEMS CAN RESULT IN A STATEMENT OF DEFICIENCIES FOR WHICH THE FACILITY MUST SUBMIT A WRITTEN PLAN OF CORRECTION. THIS INFORMATION IS THE BASIS FOR CONDUCTING FOLLOW-UP OR MONITORING ACTIVITIES TO ASCERTAIN PROGRESS AND ASSIST THE FACILITY IN CARRYING OUT ITS CARE REQUIREMENTS. IF THE FACILITY HAS MORE SERIOUS COMPLIANCE PROBLEMS, IT IS TERMINATED FROM THE MEDICARE AND/OR MEDICAID PROGRAM.

WHILE TERMINATION IS THE LAST RESORT, WE WILL NOT HESITATE TO EXERCISE OUR AUTHORITY AND TERMINATE FACILITIES. DURING FISCAL YEAR 1985, 130 SNFs AND 108 ICFs WERE TERMINATED FROM PARTICIPATION UNDER THE MEDICARE AND MEDICAID PROGRAMS.

NEW TERMINATION INSTRUCTIONS

IN ORDER TO EXPEDITE THE TERMINATION OF SUBSTANDARD NURSING HOMES, WE IMPLEMENTED REVISED TERMINATION PROCEDURES IN DECEMBER 1985. THE NEW PROCEDURES WILL:

- ACCELERATE THE PROCESS FOR TERMINATING FACILITIES WITH IMMEDIATE AND LIFE-THREATENING SITUATIONS;
- SET PROCESSING TIME LIMITS FOR ALL STEPS IN THE TERMINATION PROCESS;
- CLARIFY PROCEDURES AND PROGRAM REQUIREMENTS; AND
- MONITOR CAREFULLY ADHERENCE TO PROCEDURES FOR TERMINATION.

WE SHOULD BEGIN TO SEE THE EFFECTS OF THESE NEW TERMINATION PROCEDURES ON ALL SEGMENTS OF THE NURSING HOME SYSTEM. BENEFICIARIES WILL BE EVEN FURTHER ASSURED THAT CARE AND SERVICES OF HIGH QUALITY WILL BE FURNISHED BY FACILITIES AND THAT, IF NECESSARY, THEY WILL BE RELOCATED TO NURSING HOMES THAT FURNISH THE REQUIRED LEVEL AND QUALITY OF CARE. PROVIDERS WILL BE GIVEN A CLEAR STATEMENT OF PROGRAM REQUIREMENTS AND WILL HAVE INCREASED INCENTIVES TO IMMEDIATELY CORRECT DEFICIENCIES. STATES AND REGIONAL OFFICES WILL BE REWARDED WITH UNIFORM

PROGRAM REQUIREMENTS AND WILL HAVE THEIR ROLES AND FUNCTIONS CLARIFIED IN THE ENFORCEMENT PROCESS.

FEDERAL MONITORING

AS PART OF ITS ROLE IN OVERSEEING THE OPERATION OF THE SURVEY PROCESS, HCFA CONDUCTS FEDERAL ONSITE SURVEYS THROUGH OUR REGIONAL OFFICES OF A SAMPLE OF ALL TYPES OF FACILITIES TO DETERMINE THE EXTENT THAT STATE SURVEY AGENCIES ACCURATELY IDENTIFY FACILITY DEFICIENCIES. WHEN HCFA REVIEWS CERTIFICATION OF FACILITIES THAT PARTICIPATE ONLY IN MEDICAID, IT IS REFERRED TO AS "LOOK BEHIND," I.E., A LOOK BEHIND OF THE STATE DECISION TO CERTIFY. THIS IS SPECIAL AUTHORITY CONGRESS GAVE THE SECRETARY TO MAKE INDEPENDENT DETERMINATIONS OF FACILITIES COMPLIANCE WITH FEDERAL REQUIREMENTS

IN FISCAL YEAR 1985, WE BEGAN INITIATIVES TO INCREASE OUR USE OF THE LOOK BEHIND AUTHORITY. BECAUSE OF THE PARTICULAR VULNERABILITY OF THE RESIDENTS AND IDENTIFIED PROBLEMS, HIGHEST PRIORITY WAS ACCORDED PUBLIC ICFS FOR THE MENTALLY RETARDED.

DURING THAT YEAR WE PERFORMED 464 LOOK BEHIND SURVEYS AND IN FISCAL YEAR 1986, WE PLAN TO COMPLETE 800 RESURVEYS. OUR FISCAL YEAR 1987 BUDGET CALLS FOR CONTINUED, AGGRESSIVE USE OF THE AUTHORITY WITH RESURVEYS HEAVILY TARGETED AT FACILITIES THAT HAVE A PATTERN OF NONCOMPLIANCE WITH CARE REQUIREMENTS.

I ASSURE YOU THAT OUR RECORD IN THIS AREA HAS MADE OUR COMMITMENT TO ENFORCEMENT QUITE CLEAR TO THOSE WHO MIGHT THINK OTHERWISE.

PATIENT CARE AND SERVICES (PACS) TOOL

THE CURRENT SURVEY PROCESS FOCUSES ON PHYSICAL PLANT AND WRITTEN POLICIES ON THE ASSUMPTION THAT IF CERTAIN STRUCTURES ARE SAFE, QUALIFIED STAFF ARE PROPERLY DEPLOYED, AND APPROPRIATE PROCESSES ARE IN PLACE, GOOD CARE WILL BE ATTAINED. HOWEVER, IT HAS BECOME EVIDENT TO EVERYONE CONCERNED ABOUT NURSING HOME CARE THAT IT IS IMPORTANT TO EMPHASIZE OUTCOMES THROUGH THE SURVEY PROCESS.

BEGINNING IN 1978, THE DEPARTMENT APPROVED A NUMBER OF DEMONSTRATIONS AND EXPERIMENTS WITH THE OBJECTIVE TO DEVELOP A MODIFIED SURVEY PROCESS THAT WOULD IMPROVE SURVEY AND CERTIFICATION FOCUSING ON ACTUAL CARE DELIVERED RATHER THAN PROCESS REQUIREMENTS.

IN 1982, HCFA BEGAN TO DEVISE A NEW SURVEY TOOL, BASED ON THE RESULTS OF THOSE EXPERIMENTS, WHICH IS COMMONLY REFERRED TO AS THE PATIENT CARE AND SERVICES (PACS) TOOL. WE PUBLISHED A NOTICE OF PROPOSED RULEMAKING IN THE FEDERAL REGISTER ON THE PACS SURVEY TOOL ON OCTOBER 31, 1985, AND THE FINAL RULE SHOULD BE PUBLISHED AND IMPLEMENTED IN THE NEAR FUTURE.

PACS HAS TWO KEY FEATURES:

- FIRST, IT IS A RESIDENT-CENTERED APPROACH. IT PROVIDES A MORE VALID ESTIMATE OF THE QUALITY OF CARE FURNISHED BY THE FACILITY. BY BRINGING SURVEYORS FACE-TO-FACE WITH A REPRESENTATIVE SAMPLE OF PATIENTS OR RESIDENTS, IT ENABLES SURVEYORS TO MORE ACCURATELY IDENTIFY THEIR NEEDS AND PROBLEMS, AND, SUBSEQUENTLY, TO DETERMINE HOW WELL CARE IS PROVIDED TO MEET THESE NEEDS.
- SECOND, BY REQUIRING SURVEYORS TO FOLLOW SPECIFIC PROCEDURES AND TO REVIEW ACCORDING TO A SPECIFIED CHECKLIST, IT ACHIEVES GREATER CONSISTENCY IN SURVEY METHODS AND FINDINGS.

ALTHOUGH IT STILL ENSURES COMPLIANCE WITH ALL FEDERAL REQUIREMENTS THE MOST INNOVATIVE PACS COMPONENTS ARE THE THREE ACTIVITIES THAT FOCUS ON A SAMPLE OF THE PATIENTS OR RESIDENTS:

- INDEPTH REVIEW OF FURNISHED CARE THROUGH OBSERVATION, INTERVIEW AND RECORD REVIEW;
- EVALUATION OF MEALS, DINING AND EATING ASSISTANCE; AND
- EVALUATION OF DRUG ADMINISTRATION.

AS A RESULT OF THESE REVIEWS OF PATIENTS AND STAFF, A SURVEYOR CAN IDENTIFY PATTERNS AND AREAS WHERE THE FACILITY APPEARS TO HAVE PROBLEMS IN ADDRESSING AND PROVIDING CARE. THE SURVEYOR CAN THEN DETERMINE, BASED ON THE NATURE AND NUMBER OF THESE FINDINGS, WHETHER DEFICIENCIES EXIST AND DISCUSS THEM WITH FACILITY STAFF.

A GREAT DEAL OF THE PACS EFFORT HAS BEEN MADE POSSIBLE BY THE FULL COOPERATION OF CONSUMER ADVOCATES, THE NURSING HOME INDUSTRY, AND REPRESENTATIVES OF STATE GOVERNMENTS. IN FACT, THE CONTINUING SUPPORT OF ALL THESE GROUPS AND THEIR ENDORSEMENT OF OUR ACTIONS HAS GIVEN US CONFIDENCE THAT WE HAVE INDEED TAKEN A MAJOR STEP TOWARD IMPROVING OUR ASSESSMENT OF CARE RENDERED IN NURSING HOMES.

INTERMEDIATE SANCTIONS

AS I DESCRIBED EARLIER, IF A STATE SURVEY AGENCY DETERMINES THAT A SNF OR ICF PROVIDING CARE TO MEDICARE AND MEDICAID BENEFICIARIES DID NOT COMPLY WITH ONE OR MORE OF THE CONDITIONS OF PARTICIPATION OR STANDARDS, THE ONLY SANCTION AVAILABLE TO HCFA OR THE MEDICAID AGENCY IS TO TERMINATE THE FACILITY'S PROVIDER AGREEMENT. WHILE WE HAVE RECENTLY IMPLEMENTED THE NEW TERMINATION PROCEDURES, TERMINATION OF A FACILITY IS SOMETIMES NEITHER FEASIBLE NOR DESIRABLE.

UNDER FINAL REGULATIONS WHICH SHOULD BE ISSUED IN THE NEAR FUTURE, HCFA AND STATES WILL HAVE AN ALTERNATIVE TO TERMINATING MEDICARE AND MEDICAID PROVIDER AGREEMENTS WITH FACILITIES THAT ARE FOUND TO BE OUT OF COMPLIANCE. IN FACILITIES WITH DEFICIENCIES THAT DO NOT POSE IMMEDIATE JEOPARDY TO THE HEALTH AND SAFETY OF PATIENTS, HCFA AND STATE MEDICAID AGENCIES WILL HAVE THE OPTION OF EITHER TERMINATING THE AGREEMENT OR DENYING

PAYMENT FOR NEW ADMISSIONS FOR A PERIOD OF UP TO 11 MONTHS WHILE DEFICIENCIES ARE CORRECTED. IF A HOME WHICH HAS BEEN LEVIED THE INTERMEDIATE SANCTION REMAINS OUT OF COMPLIANCE AT THE END OF THIS PERIOD, THE SECRETARY IS TO BEGIN TERMINATION PROCEDURES IMMEDIATELY.

THIS NEW ENFORCEMENT TOOL IS INTENDED TO ENSURE THE UNINTERRUPTED STAY OF A NURSING HOME'S PATIENTS WHILE PROTECTING THEM FROM POTENTIALLY HARMFUL EFFECTS ARISING FROM PROLONGED EXPOSURE TO SUBSTANDARD CONDITIONS. WHERE APPROPRIATE, WE INTEND TO UTILIZE THIS AUTHORITY AGGRESSIVELY AGAINST FACILITIES PROVIDING LESS THAN ADEQUATE LEVELS OF CARE.

FUTURE ACTIVITY

AS I NOTED, EVEN THOUGH WE FEEL THAT WE DO A GOOD JOB IN ADDRESSING PROBLEMS AND COMPLAINTS ABOUT NURSING HOME CARE AS THEY ARE IDENTIFIED, WE KNOW THAT THE SYSTEM IS NOT PERFECT. BOTH MONITORING OF NURSING HOMES AND COVERAGE OF SUCH CARE FOR MEDICARE AND MEDICAID RECIPIENTS NEED CONTINUING EXAMINATION AND IMPROVEMENT. I WOULD LIKE TO BRIEFLY DESCRIBE FOR YOU OUR REVIEW OF A RECENTLY RELEASED STUDY BY THE INSTITUTE OF MEDICINE.

THE NURSING HOME REGULATORY AND ENFORCEMENT REQUIREMENTS HAVE IN THE PAST BEEN THE SUBJECT OF MUCH REVIEW AND PROPOSED REVISION.

UNFORTUNATELY, THESE ARE CONTROVERSIAL AREAS WHERE KNOWLEDGEABLE PEOPLE WITH STRONG OPINIONS AS WELL AS GOOD INTENTIONS SOMETIMES DISAGREE. TO HELP DEAL WITH THESE ISSUES IN AN OBJECTIVE MANNER, IN OCTOBER 1983 WE FUNDED THE INSTITUTE OF MEDICINE (IOM) OF THE NATIONAL ACADEMY OF SCIENCES TO STUDY THE FULL RANGE OF NURSING HOME REGULATORY AND ENFORCEMENT ISSUES AND TO PROVIDE RECOMMENDATIONS FOR CHANGES TO THE SYSTEM.

THE $1.6 MILLION STUDY WAS COMPLETED WITH THE ISSUANCE OF THE IOM'S REPORT IN MARCH OF THIS YEAR. HCFA HAS BEGUN A CAREFUL REVIEW OF THE IOM'S COMMENTS AND RECOMMENDATIONS TO DETERMINE WHAT IMPROVEMENTS CAN BE MADE TO THE CURRENT LONG-TERM CARE SYSTEM. HOWEVER, WE FEEL THAT A REPORT WITH SUCH SCOPE AND COMPLEXITY DESERVES AN EQUALLY THOROUGH AND EXHAUSTIVE REVIEW BY THE DEPARTMENT PRIOR TO RESPONDING TO THE STUDY'S RECOMMENDATIONS. I ASSURE YOU THAT BOTH THE SECRETARY AND I WILL FULLY EXAMINE THESE ISSUES AND MAKE DECISIONS IN THE BEST INTERESTS OF THOSE WE SERVE.

SUMMARY

MR. CHAIRMAN, WE ARE FULLY COMMITTED TO PROTECTING OUR ELDERLY AND SICK WHO RESIDE IN NURSING HOMES. I THINK THIS COMMITMENT IS CLEARLY EVIDENCED BY THE WORK WE HAVE DONE TO DATE, BUT, MORE IMPORTANTLY, BY THE FACT THAT WE ARE CONTINUING TO SEEK

IMPROVEMENTS IN BOTH OUR REQUIREMENTS AND ENFORCEMENT SYSTEMS. WE ARE ABOUT TO IMPLEMENT THE PATIENT-ORIENTED PACS SURVEY TOOL WHICH WILL IMPROVE OUR ASSESSMENT OF CARE RENDERED IN NURSING HOMES. WE HAVE INAUGURATED NEW TERMINATION PROCEDURES TO SWIFTLY DEAL WITH NURSING HOMES WHICH FAIL TO CORRECT SUBSTANDAR DEFICIENCIES IN AN EXPEDITIOUS MANNER. THE INTERMEDIATE SANCTIONS REGULATIONS WILL BE IMPLEMENTED SOON AND WILL BE ANOTHER WEAPON IN OUR ARSENAL TO COMBAT SUBSTANDARD CARE. TO CONSIDER FUTURE OPTIONS IN MONITORING ACTIVITIES, WE ARE REVIEWING THE IOM STUDY.

THIS IS AN EXCITING TIME IN THE EVOLUTION OF CARE FOR RESIDENTS IN NURSING HOMES. WE HAVE INDICATED OUR COMMITMENT TO RESOLVING PROBLEMS AND WE WILL STRIVE TO ASSURE THAT NOTHING LESS THAN HIGH QUALITY CARE IS PROVIDED TO ALL THOSE RESIDENTS.

I WILL BE HAPPY TO ANSWER ANY QUESTIONS THE COMMITTEE MAY HAVE.

Let us assume that you do need some time to study your study, and integrate it with what you want to do. How long will it take you to decide whether or not to make changes?

Dr. ROPER. Senator, we want to do it very quickly. The PACS recommendation, is not a perfect answer to the problem of assuring quality, but everybody who has taken a look at it thinks it is better than what we have got right now. And while we are waiting on the perfect, we do not want to hold off implementing the good, and so we are going to be moving quickly on PACS.

And to your question of when we are going to take the next step—just as soon as possible.

Chairman HEINZ. Will that be this year?

Dr. ROPER. We have a team of people looking at the recommendations right now——

Chairman HEINZ. Let me tell you why I am concerned——

Dr. ROPER [continuing]. If I could just answer—implementation of a number of the IOM recommendations require changes in law at the State level, some at the Federal level. It will be done as quickly as possible. We do not want to wait.

Chairman HEINZ. My concern—and Senator Cohen touched on it in his remarks—is that we first mandated the development of a PACS kind of approach back in the mid-1960's, and here it is almost halfway through 1986. That is about 20 years.[8]

Now, the reason I am pressing you on how quickly you are going to act on the study that you yourself—yourselves—you were not there at the time, but the Department—commissioned is that we do not want to wait another 20 years.

Can you give us any assurance that you will be able to come to grips with the findings and make decisions—whether or not you have the power to implement is one thing; Congress may have to be helpful to you—but can you say to us that you will come to conclusions within 6 months or a year?

What can you say to us?

Dr. ROPER. I understand the urgency in your question, sir, and I just want to tell you that I have that same urgency. I hesitate to make a commitment because something I have not personally focused on is what the time frame is, but I am told that we are doing it very quickly.

Chairman HEINZ. How soon will you be able to tell us how long it will take you?

Dr. ROPER. I would think within a month or two, something like that, yes, sir.

Chairman HEINZ. All right. Do you mind if we hold you to that?

Dr. ROPER. I would be glad to respond to you, sir.

Chairman HEINZ. You are learning fast. [Laughter.]

One other reason I am kind of impatient on this is that this committee—and you touched on this in your statement—has been told twice before that intermediate sanction regulations would be released soon.[9] That law was passed in 1980. And in your remarks, you say that you are about to come forward with them.

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[8] See appendix 4, p. 818 for *Smith* v. *Bowen* documents.

[9] "Please see volume II, appendix 6, letter to DHHS Secretary Heckler dated 12/16/83, letter to Senator Heinz dated 1/12/84, and letter to DHHS Under Secetary Baker dated 11/13/84."

That is really going to happen, is it?

Dr. ROPER. Yes, sir.

Chairman HEINZ. My time has expired.

Senator Pryor.

Senator PRYOR. I do not even know where to start, Mr. Chairman. I have got several questions. But I think first, rather than a question, Dr. Roper, I just have a suggestion.

I think that if I were you, in your spot at this time—and I know it is a difficult position—I think if I were you that on Monday morning—that is Memorial Day, so Tuesday morning of next week—I would invite and strongly encourage all of the 50 States to have a representative not only from their nursing home industry—and I use that word again—here in Washington to meet with you, but also the head person or the officer in charge of, let us say, the Department of Human Services on the local level that has jurisdiction over this issue. And if I were you, I would read them the riot act, and I would tell them that the Congress is going to respond to this report—we are going to respond to this report—and the only way we are going to get this thing straightened out is for them to know what the rules are and how serious we are about coming out of this thicket. And we are in a thicket. We are in a bureaucratic thicket.

I was just wishing today, Mr. Chairman, that we might have had some sort of a diagram to show this jungle of bureaucracy where somewhere down at the very end, there is that poor patient, who does not understand it, a jungle of bureaucracy that includes the Federal Government, the State government, the local government, Medicaid, and Medicare, the VA, the HUD people, the HCFA people, the State inspectors—and all across the land, this bureaucracy is an absolute nightmare.

Let me ask you this question. Who is in charge? Who is in charge and who is responsible for this?

Dr. ROPER. HCFA is responsible. The States are also responsible. And I understand your concern that we work together effectively, Senator, but that is happening. The thing that I would point out to you is—although I have not yet had a chance to see the report that the committee has prepared—the fact that your surveyors have found increased numbers of violations may mean that people are being more aggressive in identifying violations. And what we need to take a careful look at is whether the problem is getting worse, or whether we are doing a more aggressive job of looking for problems.

The real question that follows from that is, What is the Federal Government going to do about it, and then what are the States going to do about it?

Senator PRYOR. Does HCFA have the power to do anything about it?

Dr. ROPER. Yes, sir.

Senator PRYOR. On its own?

Dr. ROPER. Yes, sir.

Senator PRYOR. Can HCFA make a decision and override a State body in this area?

Dr. ROPER. That is what the look behind process is all about, yes, sir, and we have been doing that for 2 years now.

Senator PRYOR. Do you plan to do this?

Dr. ROPER. Yes. We plan to continue to do it, and it has been done, as I said, for years now.

Senator PRYOR. What sanctions are you going to recommend if a nursing home is in violation and continues to be in violation?

Dr. ROPER. Well, the sanctions that have been available and will continue to be are the ultimate sanction of cutting off payment for patients.

Intermediate sanctions that will very shortly be available will be less severe, such as stopping new payment for new patients in such a nursing home. We have control of the purse, and that is a great deal of leverage.

Senator PRYOR. But if you choose the sanction of did you say cutting off the payments for the patient——

Dr. ROPER. Yes, sir.

Senator PRYOR. Then what happens to the patient?

Dr. ROPER. If we cut off payment totally to all Medicare and Medicaid patients in a nursing home, then they have to be moved to another facility.

Senator PRYOR. And where are those facilities?

Dr. ROPER. In that same local area is the best place. But you point out a real problem——

Senator PRYOR. Is there not a shortage of facilities and beds at this time?

Dr. ROPER. In many areas, there are, yes, sir. That is why it is important not simply to go in with heavyhanded sanctions if we can work in a way that improves the care that is being given so that patients can continue to be cared for; that is much better.

Senator PRYOR. Well, my time is up, Mr. Chairman.

Dr. ROPER. You look as though you did not hear me.

Senator PRYOR. Well, I am pretty astounded that one of the sanctions you are considering is—where have I missed a step here? How could you cut off the payments to the patients when they are not at fault?

Dr. ROPER. No; I have not said cut off payments to the patient. I said cut off payments to the nursing home——

Senator PRYOR. For that particular patient.

Dr. ROPER. Right.

Senator PRYOR. And suddenly, that patient has no bed the next day.

Dr. ROPER. The ultimate leverage we have is the money that is paid from public programs to the facility; yes, sir.

Senator PRYOR. I think we have got a long way to go here. And my time is up, Mr. Chairman. Thank you.

Chairman HEINZ. Senator Pryor, thank you.

Senator Chiles.

Senator CHILES. I listened again to your saying the question now becomes what are we in Congress going to do about it? You know, I kind of think the question should be why haven't you done something about it?

We are talking about a 2-year study that is done by the committee. Those facts are not secret, the facts that the committee had, the facts of the abuse. Certainly, HCFA knows about that. The

committee staff got them from the records you require. That is where they got their information from.

So the question, rather than what do we do about it, now, like this has suddenly appeared—the question is, What have you done about it?

Dr. ROPER. Senator, I——

Senator CHILES. Why haven't you done anything about it?

Dr. ROPER. OK. Thank you for your question.

Again, I have not seen the study yet, but I have explained to you a number of steps that have been taken over the previous years and some of the things that are about to be done additionally.

The issue at hand is what can be done to improve the quality of care in nursing homes, and I think we have made substantial progress already.

Senator CHILES. Well, a couple of years ago we know the administration was planning to issue new regulations regarding nursing home survey and certification rules.[10] At that time, there was a lot of fear that loosening those standards could cause us to have a problem. I do not think we realized how big the problem was at that time. But the Appropriations Committee, as a result of the action taken by some of us, blocked your issuing those looser standards and required further study before you could lower the quality of care and loosen those standards.

I understand the Institute of Medicine has subsequently undertaken such a study and issued their report. I have not studied their report, but I know that they also were quite critical of your current methods of enforcing quality of care.

So, if we were not enforcing what we had, and then you were proposing over the last 2 years to loosen the certification requirements, and now you are saying, "Well, we have been working on this for a couple of years," it seems to me you were working to loosen what was not working to start with; that you were going to make it more lax.

Dr. ROPER. No, sir. We are working to enhance the control and to tighten enforcement to make sure that substandard homes are taken out of business.

Senator CHILES. Well, have you used your ultimate authority?

Dr. ROPER. Yes, sir.

Senator CHILES. Have you withheld the payments from anybody? Have you shut down somebody? Have you——

Dr. ROPER. Yes. I mentioned that in my testimony.

Last year, 130 skilled nursing facilities, 108 intermediate care facilities.

Senator CHILES. Well, are you delaying payments to nursing homes the same way you are now delaying payments in Medicare coverage? [11]

Dr. ROPER. No, sir.

Senator CHILES. Well, Mr. Chairman, I am holding a hearing as you know under the Aging Committee in Jacksonville on Friday. What we have been told is that HCFA has gone from what was 9 days in payment of claims—or, this is the testimony I am getting

[10] Please see Federal Register dated 5/27/82, page 23404.
[11] Please see 5/23/86 Hearing of Special Committee on Aging, Serial No. 99-20.

from Florida; I do not know whether it is true nationwide—to now 18 days, and they have now issued instructions that they want a 30-day float.

HCFA says this is good business practice, that most people do not pay their bills within 30 days; but because of this we are now talking about up to 60 days for people getting their doctor bills paid.

Obviously, what is happening in my State is that those doctors that were taking assignment are saying, "We are not going to take it now." So they are failing to take assignment, which makes it 10 times worse on the Medicare recipients. I sense that some of this is happening here too, that part of our problem here is that we are going to delay payments; as some kind of bookkeeping savings or something.

We are going to wind up the end of this year, I think, with $2.3 billion in Medicare claims unpaid. I do not know what it will be next year, but probably a doubling of that, because it will go to a 30-day payment cycle. So we are building a bubble, or balloon with these unpaid claims. Some day, those bill have got to be paid.

I do not know how long we can go along ignoring this delaying process, but I sense that part of our problem here may be just part of the bookkeeping thing of "let us just delay people awhile"——

Dr. ROPER. Senator, I understand your concern about payment rate under Medicare. Since nursing homes are predominantly Medicaid payments, another program, States direct the Medicaid Programs, and that is not affected by the change in payment timetable.

Senator CHILES. My time is up.

Chairman HEINZ. Senator Chiles, thank you.

Senator Cohen.

Senator COHEN. Thank you, Mr. Chairman.

Let me say, Mr. Roper, that I am impressed with your professional qualifications, and also your commitment based upon your own personal experience with your mother.

Part of the difficulty that I have with this whole process of us being up here and you down there is that there is such turbulence within the administration that I have what Senator Heinz mentioned as deja vu. I have the feeling that I am in a penny arcade, trying to shoot a target, and every time I zero in on a target, the target keeps getting changed.

Now, my understanding is we have had one permanent Administrator of HCFA under the Reagan administration, we have had two Acting Administrators, and then you. And I do not know how long you intend to be there, but one of the problems that with Congress and how it operates is that most administrations understand that we have a very short attention span. If you just delay long enough, we will be onto some other issue, or there will be a congressional recess, or elections, or tax reform will intervene, or the budget debate will subordinate all other interests, and pretty soon we have a new Congress, and they have got to start all over again.

Now, that has been part of the process since my experience——

Chairman HEINZ. Senator Cohen, you are giving him the secrets of his trade. He has only been here 2 weeks. It would normally take him a couple more weeks to learn all of that. [Laughter.]

Senator COHEN. Senator, believe me, those who are not here today have already advised the Administrator about the process.

Dr. ROPER. For better or for worse, you have got me for a long time to come.

Senator COHEN. Well, I hope we have you. I was particularly concerned about Senator Heinz trying to pin you down about when we can expect some sort of formal notification as to what the time line is going to be. We have been strung out on this issue at least since 1973, maybe as early as 1970. We are getting impatient and I think the time is coming where the issue will reach crisis proportions. We are getting impatient and are going to demand more and more in the way of action.

You are learning fast, according to Senator Heinz. I would make one other recommendation and that is to submit your testimony on time and not wait until the evening before so that we will have more of an opportunity to review it in some detail.

Now, you stated that the termination from the Medicare/Medicaid Program is a last resort. Are there any sort of intermediate solutions or sanctions currently applied to individual nursing home operators? For example, how about the imposition of fines? Why be just forced, as Senator Pryor has said—to terminate the reimbursement to the institution, which effectively means you are throwing that patient out of the nursing home out into the street or into someone's home? Why not really hit the institutions where it hurts, by imposing a fine?

Dr. ROPER. I am not aware that that is permitted, but the intermediate sanction that many States have been implementing for some time now and that we shortly will be implementing under the Federal regulations is to say that we will continue paying for patients currently in that nursing home, but we will not allow new patients to be admitted, and we will not pay for new patients. That is a sanction.

Senator COHEN. That leaves you with the same leverage as they have now—they have the same leverage; they can continue with their existing patients and not allow any additional ones in. It really does not hit them that hard. Why not impose fines upon those institutions which are in fairly clear or indeed, flagrant violation?

Dr. ROPER. That is surely something to look at, Senator.

Senator COHEN. But why does it take some time to look at it? Isn't the imposition of fines a reasonable proposition to make in a situation like this, where an institution is getting the benefit of Federal funds and abusing those funds, in essence?

Dr. ROPER. It sounds reasonable on its face. I would be glad to take a look at it.

Senator COHEN. You also stated in your prepared testimony that surveyors can make additional unannounced visits between those of the regular announced ones; is that right?

Dr. ROPER. Yes, sir.

Senator COHEN. Are there any requirements for unannounced visits?

Dr. ROPER. Yes, they are required to do that.

Senator COHEN. They are required to do that?

Dr. ROPER. Yes, sir.

Senator COHEN. That is all I have.

Chairman HEINZ. Senator Cohen, thank you.

Senator Pressler.

Senator PRESSLER. Thank you.

I would like to say that the nursing homes that I visit in my State, I usually find in very good shape. I am very impressed with the quality of people who work in them. If there are problems, it seems that the State administrators blame the Federal Government, and they say their rules are adopted pursuant to Federal regulations.

I suppose the tone of what this committee is saying is that maybe we need more Federal requirements to meet some of the needs.

First of all, is there a distinct difference in the quality of care regionally or State-by-State throughout the country?

Dr. ROPER. I do not think there is, Senator, but I have not looked at that personally. I would be glad to do that.

Senator PRESSLER. I would very much like to submit for the record, a question to you. I know that there are some distinctions in the Aging Committee staff report among States percentagewise, but I would like to, in particular, compare my State of South Dakota to some others so I can learn more about this problem; if for the record you could submit anything you have or your staff has.

Dr. ROPER. Yes.

[Information follows:]

We are unable to provide any additional information on the reported findings of the Senate Aging Committee on their allegations of substandard care in nursing homes because HCFA did not compile the data upon which the findings are based. Since we do not know the parameters that were used in generating the data, for example, the dates of the surveys, we cannot identify the facilities involved. In addition, going back in time to reconstruct the data is impossible since the system has been updated with more recent survey information. Such updated information overlays earlier survey data, thereby eliminating the earlier data from our computer system.

The survey and certification process for nursing homes involves the inspection of a large number of facets of care provided to residents. Judging "quality of care" must involve review of the entire findings of a skilled nursing facility's compliance with the more than 500 standards and requirements for participation under the Medicare and Medicaid program. HCFA data on the compliance status of nursing homes does not indicate significant variations either regionally or State-by-State.[12]

Senator PRESSLER. Well, let me ask you, from your personal point of view, based on the tone of this hearing, does it seem to you that we are asking for more Federal regulations, or do you feel that it is just enforcement of existing State or Federal regulations?

Where is the weak point?

Dr. ROPER. What you are saying is that you want quality care given to residents of nursing homes. You have developed some data that say over time, there have been additional violations of standards found.

A point I made in answer to Senator Pryor's question is what I need to look at is whether that is a result of things getting worse,

[12] Please see volume I, page 390, and printouts in appendix 3, beginning page 514; see also volume II, pages 78 and 887.

or whether it means that the surveyors, the people going into the nursing homes, are being tougher and are giving more traffic tickets, in effect. What we really want over time is things to get better. I need to look at the study and decide what kind of recommendations to make to you as to what ought to be done.

Senator PRESSLER. Well, I certainly want to wish you well in your new job. I sense that you are going to do an excellent job, I think we are lucky to have you, and I hope you stick with it.

From time to time, I hope you tell us where you think the problems lie—because when I go into a nursing home I am told, "Well, we are so confused because we do not know exactly what the rule or regulation is;" another will tell me, "We wish we had more local autonomy." It seems as though without the Federal regulations, there are abuses—this becomes a very difficult situation. And some people say, "well, if the Federal Government makes a rule, they should pay for it." And I am one who prefers that things be done on a State level. But, the fact of the matter is that frequently, if that is done, there are abuses in many States.

So sorting all this out, I think, is a major problem that this committee and that you face.

Thank you.

Chairman HEINZ. Senator Pressler, thank you.

Senator Jeff Bingaman, of New Mexico.

STATEMENT OF SENATOR JEFF BINGAMAN

Senator BINGAMAN. Thank you, Mr. Chairman.

Chairman HEINZ. Senator Bingaman, do you have any opening remarks?

Senator BINGAMAN. I do have an opening statement, which I will put in the record, and I will just refer to it if I could.

Chairman HEINZ. Without objection, your entire statement will appear in the record.

[The prepared statement of Senator Bingaman follows:]

PREPARED STATEMENT OF SENATOR JEFF BINGAMAN

Mr. Chairman, I wish to commend you and the ranking minority member, Senator John Glenn, for holding this hearing today. This hearing is an excellent opportunity to bring forth some of the quality of care problems that plague residents in nursing homes. I welcome the testimony of the witnesses in clarifying some of these problems.

Today's hearing is a follow up to the series of PPS quality of care hearings held last fall by the Committee as well as to earlier committee hearings on nursing home care in October 1984, February 1983, and July 1982. Investigations and hearings held last year on how quality of care in Medicare is impacted by the prospective payment system (PPS) found that the number of patients discharged from hospital care and into nursing homes is increasing. Furthermore, because of PPS incentives to move patients out of hospitals in an expeditious manner, discharge planning for many of these patients is inadequate and rushed. As a result, nursing home care for these persons may be inappropriate and/or substandard.

Recently, this Committee's investigations have found that: (1) there are many repeat offenders in the number of nursing homes that provide substandard care; (2) there are serious inadequacies in care, including abuse and neglect; (3) federal and state enforcement mechanisms are often inadequate and cannot ensure quality care; and (4) consumers have a difficult time in finding quality nursing homes.

Testimony at the Committee's hearing last November disclosed that the Health Care Financing Administration (HCFA) relies on state survey and certification contractors to ascertain whether or not nursing homes provide quality care.

In New Mexico we are very fortunate because we do not have any glaring problems with quality of care in our nursing homes. This is the consensus of providers, regulatory personnel, and ombudsmen. In New Mexico we have 64 facilities that offer intermediate care (ICF) with 18 facilities offering skilled care (SNF). Sixty-one of these facilities receive federal funding while only three are licensed facilities.

This is not to say that we don't have any problems. One of our biggest problems is that New Mexico has a very weak and outdated code of state nursing home regulations. New Mexico also lacks a residents' bill of rights. The New Mexico regulations were promulgated in the early 1970's and do not reflect the current quality of care given to residents. Rather, they emphasize building code compliance which was the big issue at the time of their implementation. The state regulations are presently undergoing review and will eventually be rewritten, but progress has been slow. Until that time, however, the federal regulations are relied on to ensure and/or enforce quality of care. Therefore, I am told by New Mexicans that there is cautious optimism regarding the new patient-oriented federal long term care survey process.

Another area of concern in New Mexico is the high cost of skilled care. Currently, the cost of skilled beds is $85.00 per day. This is the third highest figure in the nation, outranked only by Alaska and New York.

Furthermore, the funding for our ombudsman program is also low. Recent figures show that we are 45th in terms of state funding when compared to all states; 46th in local funding; and 49th total funding nationwide. This affects our ability to regulate and ensure that residents are receiving the best care possible.

Like many other states, consumers in New Mexico experience difficulty in finding a quality nursing home. The ombudsman office has brochures and maintains a list of facilities in the state. But many consumers don't know of this service and therefore don't utilize it. Consumers are often unaware of the fact that facility inspection reports are accessible at local Social Security offices. These two avenues are the only formal means available to assist consumers in selecting a nursing home facility. Otherwise consumers are left on their own. Oftentimes, the main criteria in selection of a nursing home ends up being proximity of the nursing home to the resident's family.

There are some other problems with nursing homes in New Mexico. I have just enumerated a few of the major concerns.

Thank you, Mr. Chairman.

Senator BINGAMAN. Let me just ask in response to the question that Senator Cohen asked about unannounced visits, you said that there is a requirement that there be unannounced visits. The requirement is by regulation, is that correct?

Dr. ROPER. That is my understanding, yes, sir.

Senator BINGAMAN. Do you know the number of unannounced visits that are required?

Dr. ROPER. No, sir, but I will be glad to get that answer for you.

Senator BINGAMAN. Do you have any idea of the extent of the number of unannounced visits that do regularly occur that HCFA conducts?

Dr. ROPER. The ones we conduct are the so-called look behind visits—and let me get that number for you—in 1985, we performed 464 look behind surveys; it will be 800 this year.

Senator BINGAMAN. But those were not unannounced, were they? I thought a look behind survey was different from an unannounced visit. The unannounced visits are done at the State level; is that correct?

Dr. ROPER. Yes, sir.

Senator BINGAMAN. And you do not have any statistics on the extent of those by State?

Dr. ROPER. I am sure we have the statistics, and I will be glad to provide them for you.

Senator BINGAMAN. OK. That would be very helpful.

[Information follows:]

Currently there are 17,892 long-term care facilities requiring an annual survey. Attached is a chart listing the number of facilities by State.

LONG TERM CARE FACILITIES BY STATE AS OF MAY 16, 1986

STATE	SNFs	ICFs	ICFs/MR	TOTALS
AK	9	2	4	15
AL	193	18	8	219
AR	159	100	8	267
AZ	61	0	0	61
CA	1167	38	172	1377
CO	164	29	11	204
CT	197	35	88	320
DE	27	8	9	44
FL	427	4	69	500
GA	283	41	11	335
HI	27	9	7	43
IA	40	411	17	468
ID	60	2	16	78
IL	467	269	87	823
IN	203	335	194	732
KS	71	310	24	405
KY	94	122	9	225
LA	38	251	164	453
MA	305	218	38	561
MD	114	79	9	202
ME	18	125	40	183
MI	300	137	230	667
MN	372	146	360	878
MO	243	121	22	386
MS	134	21	13	168
MT	85	11	3	99
NB	42	178	4	224
NC	178	52	37	267
ND	59	23	23	105
NH	22	49	15	86
NJ	252	15	11	278
NM	16	52	13	81
NV	26	3	3	32
NY	562	38	659	1259
OH	454	498	213	1165
OK	18	356	15	389
OR	67	113	10	190
PA	583	116	117	816
RI	66	40	93	199
SC	103	29	48	180
SD	68	46	18	132
TN	87	170	19	276
TX	265	781	180	1226
UT	45	33	11	89
VA	83	98	17	198
VT	20	25	14	59
WA	249	30	38	317
WI	387	62	32	481
WV	40	56	5	101
WY	23	6	0	29
	8,973	5,711	3,208	17,892

Senator BINGAMAN. Let me ask about this issue of swing beds. You have not had a chance to see this staff report that has been prepared; is that right?

Dr. ROPER. That is correct.

Senator BINGAMAN. I understand that there is authority for the use of hospital beds to augment what is available for nursing homes where that is needed; is that your understanding?

Dr. ROPER. Yes, sir, in particular in rural areas where at times you need acute hospital beds, and at other times you need nursing home beds.

Senator BINGAMAN. To what extent is the Swing-Bed Program being used now?

Dr. ROPER. It is actively being used. Again, I do not have numbers, but I would be glad to provide them for you.

[The information follows:]

There are currently 805 hospitals approved for swing-bed participation. These hospitals have a total of 31,622 beds that may be used for long term or nursing home care.

Senator BINGAMAN. Is it your thought that it needs to be expanded, the use of hospital beds?

Dr. ROPER. That the swing-bed provision needs to be expanded?

Senator BINGAMAN. Well, does HCFA need to do more to provide hospital beds to take up the slack or to take up the demand?

Dr. ROPER. I am not sure I understand your question, but if you are saying should we—well, again, I had better just say I am not sure I understand your question.

Senator BINGAMAN. Well, it says here that—I gather there is a shortage of beds in some areas in nursing homes.

Dr. ROPER. That is correct.

Senator BINGAMAN. It says here there are 148,000 excess hospital beds in the United States. The Inspector General argues [13] that if we were to use these existing beds as swing beds, we could avoid building a great many of the nursing home facilities that otherwise would be required. I guess I am just asking if you agree with the Inspector's position that we should expand the use of hospital beds as swing beds.

Dr. ROPER. That makes good sense; yes, sir.

Senator BINGAMAN. The staff recommendations in this report, which you have not seen yet, list a whole series of recommendations which should be done either by Federal legislation or improved regulation.

If someone has not already asked, maybe you could provide for the record, once you get a chance to review those recommendations, which of them you believe would require new legislation and which ones you believe you could handle as the Administrator of HCFA.

Dr. ROPER. I will be glad to do that; yes, sir.

Senator BINGAMAN. OK.

[Information follows:]

I am now reviewing our recommendations on the Institute of Medicine's [IOM] study and will be forwarding them to the Secretary very shortly. After the Secre-

[13] Please see volume II, appendix 6, beginning page 681.

tary's review and approval, I hope to share with you our plans for making any needed changes in the Federal Medicare/Medicaid requirements which govern nursing homes.

Senator BINGAMAN. That is really all I had, Mr. Chairman.

Thank you.

Chairman HEINZ. Senator Bingaman, thank you very much.

I am going to ask just one more question—and if any other members have further questions, I will be happy to have Dr. Roper entertain them—but it is this. According to the analysis that the staff has done—and here are the printouts—about 1,100 feet of printouts of violations of not just the trivial standards among the 540-some-odd conditions of participation in the critical standards, but of the 25 most critical standards, there are 9 of them up there on the right, what they found is that of about 8,800 skilled nursing facilities, 3,000 have been violating 1 standard in the last 12 months or so; some 1,000 have violated 3 of these 25 critical standards, some of which are up there, at any one time during the last year; and then, in 3 out of the last 4 inspections, some 600 nursing homes have violated 3 or more of those critical standards. And I have called those grossly substandard, chronically substandard nursing homes.

Now, those inspections take place over several years in the case of those chronically substandard homes, so my question is this. One, as you look at the data up there on that chart, which shows that violations appear to be significantly increasing, you can say, "Well, some of it is better enforcement," but I doubt that our enforcement procedures are 100 percent better in just 2 years—that is asking a lot—or 75 percent—but they might be 20 percent better. But you cannot say that that is all just, you know, well, we are more meticulous and we have whiter gloves.

And second, we have got a very substantial portion of nursing homes, some 600—maybe 900, depending on how you want to count them—of 8,800 being year after year chronically substandard.

What is the problem? Why is this taking place?

I am glad you are moving to a patient-oriented evaluation system, but what is going on right now? Why do we seem to be falling down on the job? Is it Congress' fault? Is it your fault? Is it the States' fault? Where is the fault?

Dr. ROPER. You have asked the central question, sir. I think that my answer has to be that I want to look at your report, study the data, come up with any recommendations that we feel are warranted out of there, because as I said in my statement, we want quality care, and I know you do, and I want to work with you.

Chairman HEINZ. Well, although you are new at HCFA, you are not new to the enforcement of nursing home standards. You were in Alabama for a considerable period of time. And so you are not inexperienced in these matters.

Dr. ROPER. Yes, sir.

Chairman HEINZ. Now, even though at this point you have only been on the job for a couple of weeks, based on your experience, based on your professional training and knowledge, what would you think is the problem?

Dr. ROPER. I think a key part of the problem is we are groping for how to measure quality. We have in the past focused largely on

how many of a given kind of staff there are in a facility, how many reports are generated, those kinds of things. We are coming now, finally, to look at whether quality care is being given, and I think once that is in hand, we can begin enforcing it.

Chairman HEINZ. Let us just examine that a little bit, Dr. Roper. We do have 541 standards, and maybe some of them are groping for something, but in a skilled nursing facility where they are failing to provide adequate 24-hour nursing care, what you are talking about is having a nurse on call in the middle of the night when your mother or father has a chest pain and may be experiencing a heart attack or may be having a stroke, or may be having a seizure or may be having kidney failure. I mean, that is pretty down to earth, understandable, quality of care. And according to the analysis, the incidence of failing to meet that minimum standard has gotten 61 percent worse in the period 1982 to 1984. Now, that is not groping, unless you are the patient. Then you are groping for the button, you press it, and maybe nobody comes.

A comment? And the question is why is that happening. Who is falling down on the job?

Dr. ROPER. I think there is no question, Senator, that there are substandard nursing homes in America. Our data has shown that; your data appears to show that. What I hope to do is aggressively manage the program to make sure that that improves.

Chairman HEINZ. Well, my time has expired.

Are there any other questions from the committee?

Senator Pryor.

Senator PRYOR. Is it Bill Cohen's time, or mine?

Chairman HEINZ. It is yours, and then Bill's, and then Senator Pressler's.

Senator PRYOR. Dr. Roper, years ago when I was a Congressman—I was pretty anonymous—and still am—I went out and worked in 11 nursing homes as an orderly on the weekends. It was quite a revealing experience for me and, I must say, very educational. I got to the point where I could not find any facts out from the bureaucracy, so I sort of went out there on my own, and I got caught up in this issue.

One thing that I heard over and over again during that period was that these, "unannounced visits" were not unannounced; that the nursing home owners were tipped off before these visits occurred, sometimes as much as 2 days in advance. We even found evidence of this in my State. And I must say, Mr. Chairman, when I heard last night that my State, Arkansas, was third on the list for chronically substandard facilities, it really concerned me a great deal

What evidence are you finding today that these visits are not truly unannounced and that the nursing home owners or operators have advance warning before these people come in—these inspectors?

Dr. ROPER. Senator, that is something I have not had a chance to look into, but I surely will. Obviously, as your question indicates, what we want to make sure is that the quality is there, day in and day out, not just when the inspector is scheduled to come.

Senator PRYOR. I hope, too, that you will do something else on the inspection issue—and I do not know whether you are doing it

or not. A nursing home during the day is very different from a nursing home during the evening. I would suggest that when inspections are made that they be made during the evening.

Dr. ROPER. That is a good suggestion.

Senator PRYOR. Because it is a different place entirely. The number of personnel usually is less. Doctors are not on duty as much, and their presence, of course, is somewhat insubstantial, I think. But I hope you will consider that as a suggestion.

Chairman HEINZ. Thank you, Senator Pryor.

Any other questions?

Senator Cohen.

Senator COHEN. Just a comment to follow up on what Senator Pryor was saying. I would point out that the quality of the Senate debates are quite different in the late night and early morning hours than they are during the middle part of the day. It is my hope—and I say this not in jest—that the presence of television cameras will change, at least moderate and perhaps unify, the quality of debate during the course of the day and night. I say that with a note of seriousness, because I think it will have exactly that effect.

What Senator Pryor is saying is that we want the same sort of critical scrutiny being applied by HCFA to the quality of care that is being administered at night that is applied during the day.

I only want to make one other observation. The violations that have been listed on the board happen to deal with medical treatment for the most part. That is of critical importance. But of equal importance to me is that patients are not being treated with respect. There are patients being treated as being incapable of making choices about things as simple as what to wear, when to wake up, who to see, whether they can control their own bank accounts—things that each of us would demand as ordinary human beings. They are then being deprived of those guarantees and rights, in many instances, when they go into a nursing home.

So I would put the quality of treatment of those individuals as human beings almost on the same level of parity with medical treatment. In my judgment, that has been neglected and not focused upon at all by HCFA or anybody else. The quality of medical care is important, but the quality of treatment in terms of how the patients function as human beings is also important. I would hope that you would focus upon that as well.

Dr. ROPER. Yes, sir. Thank you.

Chairman HEINZ. Senator Cohen, thank you.

Any other questions?

[Pause.]

Chairman HEINZ. If not, Dr. Roper, I have some additional questions that I want to submit to you.[14] You are going to be very busy answering all of our questions.

Again, we welcome you to life in Washington, DC.

Dr. ROPER. It is a pleasure to be here, Senator.

Chairman HEINZ. You may have preferred it in Alabama after you get through answering the questions. And we will probably

[14] See appendix 1, p. 278 for correspondence between the Special Committee on Aging and DHHS.

want to have you back before the committee in a month or two to see how you have done on the Institute of Medicine study because, as Senator Cohen points out, we know that you know about our short attention span, so we are going to have to overcome your perceptions about our short attention span.

Dr. ROPER. Yes, sir.

Chairman HEINZ. Thank you very much.

Senator PRYOR. Mr. Chairman, I hope Dr. Roper will remember that he, like all of us, is a potential candidate to be a patient in a nursing home, eventually. That might spur him on to get to the bottom of this problem. I appreciate your comments.

Chairman HEINZ. Thank you, Dr. Roper.

Dr. ROPER. Thank you, Senator.

Chairman HEINZ. I would like to ask our next panel to come forward: Dorothy Doyle, of Alpharetta, GA; Peggy Dowling, of Napa, CA; Ralph Lopez, of Los Angeles, CA; Sandra Casper, of Madison, WI; Conrad Thompson, of Olympia, WA, and Toby Edelman, of Washington, DC.

As our witnesses are seating themselves, let me observe that our second panel here includes a total of six witnesses who have learned a great deal about the real world of chronically substandard nursing homes.

On behalf of the committee, I welcome each of you here today, and we very much appreciate your taking time away from your families, from your responsibilities, your jobs, to share with us your experiences and suggestions on how we can, indeed how we must, improve the quality of care in nursing homes.

The first two witnesses, Ms. Doyle and Ms. Dowling, are here to tell us about some of their own personal experiences. I understand that they were not very pleasant experiences, and we are sorry to have to ask you to do that, but I think it will be of help to the committee.

Mr. Lopez is chief of the health facilities division of the county department of health services in Los Angeles.

Ms. Casper is the president of the Rehabilitation Care Consultants in Madison; and Conrad Thompson is the director of the Washington State Bureau of Nursing Home Affairs.

Ms. Toby Edelman is a staff attorney for the National Senior Citizens Law Center here in Washington.

You have each submitted prepared testimony, all of which will be made a full part of the hearing record.

Let me start with Ms. Doyle who comes to us as I mentioned from Alpharetta, GA. Ms. Doyle, thank you very much for coming here. I know your two Senators, were they on this committee, Senator Mattingly and Senator Nunn, would want me to welcome you in their behalf, and I so do.

Please proceed.

STATEMENT OF DOROTHY A. DOYLE, ALPHARETTA, GA

Ms. DOYLE. My mother had Alzheimer's disease and entered the first of three nursing homes in 1980 at the age of 70. Though we were Florida residents, and I was her caregiver, I placed mom in

an intermediate care home near relatives in Georgia, because Florida Medicaid assistance at the time refused Alzheimer's patients.

Mom's care there was average, but my family was upset to find that she was tied to a chair from the time that she entered. The staff said this was for her safety.

The first Medicaid cuts resulted in a dramatic drop in the quality of mom's care. She was hospitalized with a severe infection and lost continence, along with the ability to walk, talk, and use her hands. She required an indwelling catheter.

Mom's doctor advised me that from that point, the length of my mother's life would depend entirely upon the quality of her nursing care.

I decided to move mom back to Florida, near me, where I could better monitor her care. The only bed I could find was in a home that did not accept Medicaid. About a year later, the nursing home decided for the first time to participate in the Medicaid Program. Those patients going on Medicaid were moved to another area of the home. The administrator changed, and troubles began.

The quality of mom's care went down. Her contracted hand was neglected to the point where she required surgery in order to prevent its amputation. An adequate supply of clean clothing became impossible. Shortly after one of my complaints, I found mom in bed clothed only in an undershirt, all of her clothing was dirty and a note was on her drawer saying mom's laundry was not to be done.

When I asked the administrator what was happening, he responded by shouting, "Take your mother and get out. I am sick of ungrateful deadbeats like you. Both of you get out."

He terrified me, raving, shaking his arms, pounding the wall, repeating that no matter how much he did for people like us, we did not appreciate it.

I reported the incident to Medicaid's investigative unit. Medicaid notified the home that it had 30 days to remedy violations or lose funding. Management responded by notifying all Medicaid patients they were no longer welcome.

Efforts to find mom another Medicaid bed in south Florida were unsuccessful. I no longer had the resources to "buy" mom's way into a decent home. I rejected the choice to move my helpless mother, alone, to another area of the State.

Though we had only a contingent contract on the sale of our house, we risked moving before our closing date in order to accept a Medicaid opening in what seemed an average Atlanta area nursing home.

Mom's care was average, at first. Then, except for a couple of months in the fall of 1984, it steadily declined. Mom developed another severe infection and seizure that December. The crisis passed, but for reasons unknown, her temperature went up and down, yet never left.

I found mom, elevated temperature or not, always in bed; yet only once did I ever see a turning chart. She was not given ample fluids, and her fluid intake-output chart was neglected. Needed medication was not ordered. She was not bathed. Her hair smelled. Her clothing and linen were dirty. Her room was never clean, and her furniture was covered with dried food.

The shrinking staff became indifferent and defensive. Occasionally on evening visits, I found no staff at all.

Seldom able to find linens, I began carrying Handi-Wipes to bathe mom. I dried her most times with paper towels. And then the fly infestation began. They were on her face, in her sores, on her food. Visiting my mother became a horror that left me either nauseated or in tears or both.

I had to force myself to go back for the next visit. I complained to supervision, but nothing changed. I tried to move mom out, but no nursing home would accept Medicaid without my first paying for her care for a specified number of years.

With no place to move mom, I would not chance complaining to the State. I began praying God would let my mother die.

Deeply distressed, with heavy responsibilities and limited available funds, I decided to hire a private nursing aide. It was then, when I assisted in preparing mom for her first whirlpool bath, that I found the unexplainable cause of mom's persistent temperature. My mother's lower extremities were covered with open, running, infected ulcers.

With care from the private aide, my mother's condition improved steadily. In 6 weeks, her sores were healing nicely, and her temperature was gone.

The nursing home, however, continued to be filthy and staff care poor. At the end of July 1985, my mother developed pneumonia and died.

In February this year, after a massive investigation involving the State attorney general's office, the nursing home lost its Medicaid certification due to poor infection control and conditions that posed a threat to the health and safety of patients.

Three of its employees were arrested for patient abuse. The owner, a man owning 17 nursing homes, appealed. I was one of the State witnesses for his hearing. No family members ever testified, because the State struck a deal with the owner, whereby he dropped his appeal and accepted a 120-day loss of certification. He is the same man who recently paid $525,000 to have the State drop a 1982 suit for $1 million in Medicaid nursing home overcharges.

Though it is against the law to do so, one witness, an employee of the home, was fired the day after the settlement.

Several of us who were State witnesses are pressing for further action and changes in policy. So much more needs to be done. We have reached a point in the graying of America where we can no longer leave this to tomorrow. The cost of extended nursing home care is out of reach for all but the wealthy, and we are next at the nursing home door.

[The prepared statement of Mrs. Doyle follows:]

1125 Pine Grove Drive
Alpharetta, Georgia 30201
May 13, 1986

Senate Special Committee on Aging
U. S. Senate, Room SD-G33
Washington, DC 20510.

Gentlemen.

I am grateful for the opportunity to tell you of my experiences regarding my mother's nursing home care under Medicaid. I feel that it would be useful to you if I begin when she first needed nursing care for the results of Alzheimer's disease, in 1980.

Mom had no pension though she worked eighteen years for N. J. Bell Telephone Co. and another twenty as manager of a small Florida "Mom and Pop" motel. Divorced at age sixty with no support payments, she lived on a small Social Security check and her only asset was the equity in her low-priced condo. In short, Mom had worked all her life but she was poor.

I decided in 1980 to place her in an intermediate care nursing home near my brothers in Georgia because Florida did not recognize Alzheimer's disease at that time as an adequate reason for receiving Medicaid nursing care, and I knew that we were dealing with a long-term illness. I had no way of knowing how long it would take for Mom to develop secondary problems that would be severe enough for Florida to approve her for Medicaid funding, plus I planned to move to Georgia in a year or so. Her assets of approximately $14,000 were assigned to me with the intention of using it to pay any of her expenses, through the years, that would not be covered by Medicaid, and she was accepted for Georgia Medicaid nursing home care. Georgia, at that time, paid the entire difference between the rate charged by the nursing home and Social Security benefits. Patients had their choice of any available bed in any nursing home that participated in the Medicaid program.

A combination of a dramatic drop in the quality of her care following the first Medicaid cuts and a severe infection that I feel certain was encouraged by her poor care made me decide to move Mom back down to Florida near me until I could move out of Florida myself. Mom was now unable to walk, talk, or feed herself, and she was incontinent with an indwelling catheter. Her doctor had advised me that from that point on, the length of Mom's life would depend entirely on the quality of her nursing care. I could not find a Medicaid bed for her in Florida. I could not even find a paying bed in a home that would later allow her to stay on Medicaid. That is the only way to get into a decent medicaid nursing home in Florida. You have to go in as a paying patient for a period of time up to several years or you will be put out when your money runs out. In other words, you have to have enough money to buy your way into a decent Medicaid bed. Florida pays a set rate for Medicaid nursing home care, a

rate that is below the amount charged by every institution I know of. I took the only available bed, one in a nursing home that did not participate in the Medicaid program. I hoped to be out of Florida before her money ran out. Mom's care in that nursing home was good. About a year later, her money ran out along with an additional few thousand dollars of mine. Luckily, the home decided to try taking Medicaid patients for the first time. When Mom was accepted for Medicaid assistance, she was moved to another area of the nursing home, one where the care was of lower quality.

While in that section, the home changed administrators. The new man was a cold, unfriendly person, and Mom's care further slid downward. The home began having a severe problem keeping the patients supplied with clean clothing, while the laundry room was piled high with clothing that had not been distributed. I complained several times, to the staff and administrator. Unfortunately, I made the mistake of complaining one day in front of someone who, I later realized, must have been an inspector or someone else whom the nursing home did not want to know of the problem. The home changed policy and sent out notices that the patients would have to pay extra for laundry services. I never received notice nor did I ever get a bill. When I found Mom in bed with just an undershirt on and a sign on her closet not to do her laundry, I went to the administrator and asked him what was going on.

The man shouted at me to take my mother and get out, he was sick of ungrateful "dead beats" like us and he wanted us out! He raved at me, shaking his fists and pounding on the walls, about how no matter what he does for people like us, we don't appreciate it. I was terrified. It took me two days to get up the courage to report it to the Ombudsman. She could not promise immediate attention to the matter. She had a backlog of complaints. Upon the advice of a civil rights attorney, I reported the incident to Medicaid's investigative unit. They assured me that the administrator could not throw my mother out and went in the next day and began an investigation which lasted several weeks. They found ten violations in the nursing home. They notified the nursing home that it had thirty days to comply or lose Medicaid funding. The nursing home told them to keep their funding and notified all Medicaid patients that they had thirty days to leave or begin paying.

A social worker and I tried to find a bed for Mom but we could not. Mom's funds were gone, so I had no way of buying her way into a home anymore. One home in Tamarac, Florida, told me it would take her on Medicaid immediately, if I would make a contribution to the home that would be equal to the amount she would have paid as a paying patient for six months. To my knowledge only one Medicaid patient in Mom's nursing home was able to find a bed in the area. Our only other choice was to move her to a Medicaid bed in a nursing home in another area of Florida that had an opening. That meant Mom would have no one to look out for her, something I had found to be absolutely essential for someone like her who was totally helpless, both physically and mentally. We, fortunately,

received a deposit on the sale of our home at that time. I immediately took a plane to Atlanta to see if I could find an open bed there. I found only one nursing home with an opening - actually, it had many open beds. I had been through many nursing homes by that time and this one looked average to me. It was certainly not the best I had seen, but then, neither was it the worst. I had little choice. We pushed up the closing date on our house and moved up to Atlanta. I heard from the Ombudsman just before we moved. She had gotten around to the investigation two months later, and, of course, found nothing wrong by that time.

Mom's care was pretty good when she first entered the nursing (12/83) home in Roswell, Georgia, a suburb of Atlanta. Within a few months, however, I began to notice that she was not always clean and the home began to look dirty. That summer was quite bad. I would find her in the same clothing she had been in during my previous visit days before. Her hair was dirty. She was left sitting in a mess for hours. The home acknowledged the problems and assured the families that it was taking moves to correct the situation of staff shortages. In the fall, the quality of her care began to improve some.

At the beginning of December, 1984, Mom was hit again with another severe infection and siezure, a situation similar to the one that occured in 1982 when she had been receiving poor care. This time her left hand began to contract and so did one of her eyes. The crisis passed but the infection did not leave, for reasons unknown. Her temperature spiked up and then would come down for a few days and spike up again late in the day for several days and so on. Even when her temp was down, it never was completely gone. This was an excellent excuse to leave Mom in bed and forget about her, which was precisely what happened. To make matters worse, problems began again in the spring, earlier in 1985 than 1984. I had to go in and demand care for Mom. She was left in bed all the time, regardless of her condition, she was not turned when she was left in bed, only once did I even see a turning chart; she was not bathed for months, her hair smelled and her clothing was always dirty. She developed bedsores. The room and furniture were always dirty, crusted with dried food. The staff became indifferent to Mom's needs and hostile toward me for insisting they care for her. Her bedding was usually dirty, left on for days at a time, often with the food encrusted side turned down and hidden. Needed medication was not ordered for her. There were never any washcloths for me to bathe her and seldom were there towels. I began taking Handy Wipes with me to use for washcloths and I dried her with paper towels. I began washing down her furniture with paper towels each time I visited. And then the flies came. They were all over her, on her face, in her sores, on her food. Visiting her became a horror for me that left me either nauseated or in tears or both, so that I dreaded each visit and had to force myself to go back there each time. I tried to move her, but no nursing home would take her. I complained to the staff and supervision, but in view of what happened in Florida, I decided not to report the situation to the state. It took two to three people to move Mom

I could not chance my being kept out of the nursing home, because she desperately needed someone to speak up for her, and I could not risk her being put out or revenge being taken on her. She could not even cry out for help if she needed it.

There was no way out for Mom. Since the Medicaid cuts, Georgia nursing homes had adopted the same policy as those in Florida. The state of Georgia now paid a set fee for Medicaid nursing care, regardless of the rates set by the nursing home. Nursing homes no longer wanted Medicaid patients unless they could be guaranteed that the person would enter as a paying patient for a specified period of time before applying for Medicaid - anywhere from a year to several years. Some stopped taking Medicaid patients altogether. Just like the situation in Florida, the only nursing homes that readily accepted Medicaid patients were those that were so bad that they couldn't keep their beds filled with paying patients. However, the situation is a nightmare for all families needing a bed quickly, because the most readily available nursing home beds are usually ones in the worst nursing homes.

I was willing to pay for Mom to get decent care, but Alzheimer's is such a prolonged disease that I needed to know what kind of a burden I would be placing on my family. I had already spent several thousand dollars of our funds. I tried to get Mom's doctor to give me some idea of how long I might expect her to live at that point. He refused to discuss it. I asked my doctor and got a similar response. I decided to begin using the money I had set aside for her funeral expenses to hire a private nursing aide to attend to her needs. It was then, when I assisted her aide in undressing her for her first whirlpool bath, that I discovered that Mom's lower extremities were covered with open, running, infected ulcers. The one at the base of her spine was at least three inches across with the appearance of decaying flesh. The aide, her R.N. supervisor, and I were horrified. This, obviously, was the "unexplainable cause" of her persistent temperature. Mom's condition began improving immediately. In six weeks, her sores were healing nicely and her temperature had finally gone. The nursing home continued to be filthy and the staff aides now acted as if the responsibility for Mom's care belonged entirely to the aide I hired.

At the end of July, 1985, Mom developed pneumonia and died. It is difficult to say to what extent nursing home conditions contributed to her death. I had requested a "head only" autopsy of my mother's remains as ADRDA, the national Alzheimer's organization, recommends. That might have revealed the answer, but her doctor, one of the three doctors from the only practice I have ever known to attend patients at that nursing home, refused to cooperate with my wishes. I can say that the nursing home has since lost its Medicaid certification due to poor infection control and conditions that posed a threat to the health and safety of patients to the point where they posed a threat to life. In addition, three employees were arrested regarding incidents of violence against patients at this nursing home.

The owner of the nursing home appealed the loss of his certification. I was one of the witnesses for the state for that hearing. The investigation leading up to that hearing was unprecedented in the state of Georgia. It involved the attorney general's office and large numbers of professionals and family members. It was the first time the state of Georgia had gone after a nursing home owner in that manner. Nevertheless, family members and professionals wishing to have events at that nursing home made public never got to tell their story. The owner, a man reported to own seventeen nursing homes, struck a deal with the state whereby he would accept the charges if the state would limit his loss of certification to 120 days, something he claimed would cost him $450,000. The state agreed. It feels that having gone after such a rich, powerful, influential man as this man will do much to improve nursing home care in Georgia. Indeed, the number of complaints of nursing home abuse has multiplied. However, we who lived with the horrors of that place feel more is needed. This is the same man who in 1982 was sued by the state for Medicaid fraud for overcharging nursing home residents by $1,000,000. He settled with the state for dismissal of the suit for payment of $525,100. He is said to have bragged that they didn't find him guilty last time and they wouldn't this time either. In addition to the charges directly involving this nursing home, Medicare in Illinois is currently investigating several charges of possible fraud involving the medical supplier for this nursing home. I received notice of Medicare and Medicaid payment for medical supplies charges in excess of $1,600. I know from experience those supplies should not have amounted to any more than approximately $600.

Local media coverage of these events was minimal. The majority of coverage was by one television channel. Major newspaper coverage was, in my opinion, poor. It even ran a piece with family members who still had patients in that nursing home defending the owner and administrator, a meaningless exercise, since the owner, at meetings with the family members, had attacked those of us who chose to go public with our complaints and he had promised to pay the bill for family members who couldn't find another nursing home. Under the circumstances, they certainly weren't going to tell the press anything that would anger the man. One of the nursing home's employees who was to appear as a state witness was fired the day after the settlement. That's against the law, but the law provides for no penalty. Several of us who were state witnesses are pressing for further action and changes in policy. My piece (enclosed) on that subject was printed as a letter in the Atlanta Journal-Constitution. So much more needs to be done. We have reached a point in the greying of our country where we can no longer leave this to tomorrow. The next persons suffering such abuse may be us.

Sincerely,

Dorothy A. Doyle

Dorothy A. Doyle

enclosed: copy of the record I kept of Mom's nursing home care during her final months.

Record of Patient Care & Conditions at a Georgia Nursing Home, 4/22/85-7/27/85, Regarding Angelina B. Palmieri, Resident.

by Dorothy A. Doyle, Her Daughter

Mon, Apr. 22, 1985

Occasion: Call from charge nurse. Mom has chest congestion & possibly another UT infection. She called after noting that Mom had a temp. of 103-104 F, onset Sat., but no one had called me since attempting to call me on Sat. and finding me not at home. Temp. today 101-102 F.

Findings: Mom had a mouth full of white mushy fungus. Her lips were covered with it and the skin wiped away when I tried to remove it. Mom appears to be very sick. She is unresponsive. She is dirty

My Action: Asked charge nurse coming on duty to do something about Mom's mouth infection. She protested that she had just been in there and saw nothing. I insisted she come in and examine Mom's mouth. I cleaned Mom up the best I could and gave her water.

Nurs. Home Action: Charge nurse examined Mom's mouth and acknowledged that she had a yeast infection. She said she would call in an order for Mycostatin.

My Action: Made a decision to record in writing any visit that would help describe the conditions at this nursing home and the quality of care Mom receives there.

Findings - Summary of my recollection of conditions at this nursing home, Dec. 1984 to Apr. 22, 1985: Mom is dirty. She is usually found with food on her clothing, her face, and often the bedclothes. Her hair is seldom combed and it is impossible to recall at this time when I last saw it clean. I twice placed a bit of something in her hair when I combed it and tied it into a pony tail, to see if her hair was attended to. Both times I found the same bit still in her hair when I returned four days later and five days later. She is frequently found laying in feces. I sometimes cannot find anyone who can make time to clean her up so I clean up the mess myself. There have been times when I have been there at night and not seen any staff on the floor for 30-45 mins. Washing and powdering of her contracted hand is frequently neglected though it was determined in conference with her physician and the nursing staff shortly after her admission that this was to be a daily nursing task in order to prevent a breakdown of the tissue. It has become routine for me on every visit to bring Handi-Wipes with me to use for washcloths (none are normally available) and sponge her dirty face, neck, and hands, give her water, and, frequently, change her dirty smock. I have found the same smock with the same foodstains on it still on Mom four and five days later, when I next visited. Though she is on an indwelling catheter and requires generous amounts of fluids, I frequently must go get drinking supplies in order to give her liquids. She seldom has a cup or straw or syringe handy. I bring a marking pen to note "KEEP" on any syringe I obtain from the nurse, so that it will not be thrown away and there will be a means available of giving Mom water should an aide should wish to. However, I strongly suspect that she gets no fluids other than those served with her meals. Most times I cannot find any cloth towels so I must use paper towels to dry her or a clean sheet, if the linen cart is in the hall and there are enough on it that they will not run short. Mom has developed skin ulcers. Since December, I rarely find her up and in her wheelchair. She is usually left in bed, even when her temp. is down. I make it a point to get her up myself whenever her condition permits.

Mom's room is dirty without exception. I have developed a routine of not only cleaning Mom but taking paper towels and washing the top of her nightstand and feeding table, and, often, the windowsill. I cannot recall ever finding them clean in recent months. They are always covered with dried food and liquids. The floor is always dirty. There are roaches in her closet and nightstand. Her sheets and pillowcases are often dirty. I have found the same foodstained pillowcase on her bed on my next visit four and five days later. Sometimes the side with the dried food is turned down and the clean side turned up. I change her dirty pillowcase whenever I can find clean ones on the cart, which is not often.

Tues., Apr. 23, 1985

Occasion: visit, illness

Findings: Mom more alert today. She looks tired and other than following me with her eyes, she is unresponsive. Temp. is 100 - 101F. Mouth is still full of white gunk. Hair now smells rancid.

My Action: Gave Mom sponge bath to extent I could. I requested someone clean the fungus out of her mouth.

Nurs. Home Action: Cleaned Mom's mouth. Took 3 pkts. of swabs to clean it.

Wed., 4/24/85

Occasion: visit, illness

Findings: Mom much more alert, cough looser. Mouth appears to be pretty clean. Her contracted hand smells.

My Action: Sponged off Mom and changed some of her linen. Washed and powdered her hand. Mom's left hand is now contracting. I have tried to find washcloths to roll and place in it to keep it open but there are never any. Today I use several paper towels rolled together, as I regularly do.

Findings: Crumbs of dead skin coming off inside of hand seemed endless, indicating that hand has been negelected for a while.

Nurs. Home Action: none observed

Thur., 4/25/85

Occasion: Could not cope with visiting Mom again today. Though I feel she could use my assistance, I cannot bear to see her dirty and smelling again.

My Action: none

Fri., 4/26/85

Occasion: visit, illness

Findings: Mom's condition worse. Temp. 101 F. Her mouth is full of white fungus gunk again. She is experiencing discomfort when swallowing liquids. I suspect the infection may now be in her throat.

My Action: Performed routine tasks. Checked with charge nurse to be certain medication had been given for mouth condition.

Findings: Medication had never been ordered for mouth infection, though nurse had acknowledged her condition on Mon. and promised to call for medication.

My Action: I insisted a medication request be placed ASAP.

Nurs. Home Action: Obtained order for Mycostatin from doctor's assistant, who I am told is in nearly every day

Sun., 5/12/85

Occasion: visit, Mother's Day

Findings: Mom and room dirty, as usual. Room infested with flies and smells strongly of urine and feces. Soapdish has collected 1/4" of soap drippings now. Fluid intake/output chart is outdated. Incomplete entries of later dates are written in the margins.

My Action: Perform routine tasks of cleaning up Mom and her tables. Jeff tried to get rid of some of the flies.

Nurs. Home Action: none observed

5/13/85 -5/26/85

My Action: Visited various nursing homes again. Found one very good one, but it will not take Mom with open sores. Put Mom on several waiting lists. I strongly suspect that her Medicaid status is unwanted

Mon., 5/27/85

Occasion: routine visit

Findings: Mom is filthy. Could find no towels nor sheets nor any other linens to use to wash and dry her. Her forehead is creased and her eyes tensed; she appears to be in pain, yet I cannot find anything other than a few sores when I check her. My relationship with the staff has become cold and tense because everytime I come in, I politely but persistently ask them to attend to her. Another patient's daughter was sounding off about the nursing home in the upstairs hall as I was leaving.
to
My Action: Decided to begin using money I saved for Mom's funeral expenses to hire a private aid since I cannot find an opening in another nursing home and I see no evidence of the conditions and care of Mom improving.

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Wed., 5/29/85

Occasion: Notify nursing staff that I had hired a private aide from Health Care to come in three times a week.

Findings: Met with Dir. of Nursing. She told me she was 40 aides short a few weeks ago and 26 short the beginning of this week and 20 short now. She tried to tell me this is a seasonal problem, however, I have seen it this way for a year except for the few months before Christmas '84.

Nurs. Home Action. Dir. promised to work with the aide and promised to set up a plan for improving Mom's care. Was told she would be right down to see the charge nurse. I waited until after 3 p.m. but she never came down. I explained my plans to the charge nurse myself. She apologized to me for the situation.

Thur., 5/30/85

Occasion: Meet with representatives of Health Care Services to set up a program for Mom's care

Findings: Hannah, the aide, and I prepared Mom for her first whirlpool bath. I soon discovered why Mom has appeared to be in pain. We found Mom's legs, feet, hips, and thighs covered with puss-ridden, running, 1" - 2" sores up to 1/2" deep. The sore at the bottom of her spine is at least 3" across and the flesh is so broken down that it smells like decay. John ___, RN, Kelly supervisor indicated that it was evident Mom had been "neglected for quite a while."

My Action: Discussed Mom's problems and needs with John ___ and Hannah ___ and set up a program for her care by Hannah three times per week to include:

* Whirlpool bath and wash hair
* wash, dry, powder hand
* feed midday meal
* give fluids
* change Mom's clothing
* change bedclothes
* get Mom up and into her wheelchair unless she has more than a low-grade temperature

Nurs. Home Action: Staff promised to assist Hannah in any way. "Just ask."

Sun., 6/2/85

Occasion: routine visit

Findings: Mom was in bed. Her temp. 99.4 F. Mom laying in feces. Aides on floor very busy.

My Action. Requested from Charge Nurse the Nursing Home's policy regarding getting Mom out of bed. Told there was none. Sponge bathed Mom and cleaned up the mess she was laying in. Got her up into her wheelchair. I requested it be put on record that I wanted Mom out of bed for at least a short time on every day when she had no elevated temperature.

Thur., 6/6/85

Occasion: Letter arrived from Nursing Home Administrator stating that people who were unhappy with loved ones care at Nursing Home were probably just upset because they were suffering from "guilt." Administrator suggested anyone unhappy with the nursing home should remove their loved one. To me, the letter confirmed my belief that callousness and lack of compassion for the sick and suffering at this Nursing Home is a matter of policy.

Sun., 6/9/85

Occasion: routine visit by Bill & me

Findings: Mid-afternoon. Mom was still not cleaned up for the day and was still in bed.

My Action: Request that staff attend to Mom's needs

Nurs. Home Action: Cleaned Mom up for the day

Sat., 6/15/85

Occasion: routine visit by Bill, Jeff, me

Findings: Fly infestation very bad today. Jeff, who has not seen her in a while, remarked that you could tell she had an aide coming in because she appeared to be in the best condition of anyone he saw. The room is still filthy and the soap builds on.

Mom's condition and appearance have improved dramatically in the two weeks since her care by the private aide began. Her hair is always clean and her clothes and bedclothes are at the worst two days old now. Her sores are healing nicely. She is more alert.

My Action: Room cleaning routine.

Sun., 6/23/85

Occasion: routine visit, Bill & me

Findings: 2:30 - 3:00 p.m. Mom unchanged from night before. Though it is hot outside and the temp. is expected to be in the 90's today. Mom is dressed in a long-sleeved, flannel nightgown with a closed front, covers pulled up over her arms. Air conditioner is off, window open. Mom is sweating profusely and the skin on inside of her hands is white and puckered as when hands are left in water too long. Her water pitcher is empty and literally covered with dried, pureed food. Intake/Output chart expired on 6/20/85. There is no hot water to bathe her, the second time I have found that recently. She has dried food on her face and hands and mouth.

My Action. Cleaned her up, removed flannel gown, and put on a cotton smock. Only washed her hands due to cold water. Bill asked for a new pitcher at the nurses' station and was told they would get one later. He asked where he could get one for them. He obtained a pitcher from upstairs but there was no ice nor lids. We gave her water. I removed the outdated fluids chart and took it to the charge nurse.

Findings: Mom was frantic to get the water. She couldn't get enough. Bill was afraid to give her more than 1/2 of a pitcher. (Mom always hated water.)

Nurs. Home Action. The five people at the nurses' station, including, I believe, two nurses, were arguing about who should have bathed Angie today.
A new Intake/Output chart was put up.

Tue., 6/25/85

Occasion: 1:30 - 2:00 p.m., visit to check on assistance given to aide.

Findings: Found Hannah very upset. Sat. she found Mom dressed in a long-sleeved flannel nightgown with the covers pulled up the windows open, the A/C off, though Sat. was a hot day. She said Mom's color was so poor that she was afraid for her. She complained that she gets little cooperation from the staff, and now that they know when she is coming in, they do nothing at all for Mom on those days and have even left her in feces and tried to make it appear that she just had the BM. She could not bathe Mom Sat. either because there was no hot water. She said the staff is often acting spiteful because of her complaints against their poor care of Mom and the condition she finds her in. They are not cooperative and will not break up a conversation to help her lift Mom. She had asked the charge nurse 30-45 min. before I arrived to dress Mom's sores because she had to leave soon to catch her bus, but the nurse had not yet come in. Hannah threatened to quit caring for Mom because she was tired of them never having necessary supplies and tired of finding Mom and the place such a mess. She, too, has been washing the furniture with paper towels.

The flies are awful today. They are walking all over Mom, in her sores, over her food.

My Action: Went to find the nurse to dress Mom's sores.

Nurs. Home Action: Upon seeing me coming, the charge nurse jumped up and called out, "Oh, I was just coming in to take care of Angie."

My Action: I drove Hannah to the bus stop to try to avoid having her miss her bus

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6/25/85

Occasion: 8:00 - 9:00 p.m., Lisa (my dtr.) visited Mom

Findings: Mom laying in feces. No staff seen nor heard on the hall throughout her entire visit.

Her Action: She got the Chux herself and cleaned up the mess and Mom. (She has done this on several visits when either finding no staff on the floor or finding the staff so burdened that making time to care for Mom would be difficult.)

Wed., 6/26/85

Occasion: Tried once again to find another nursing home for Mom.

Results: No openings. The good ones have waiting lists for Medicaid beds, one has a two-year list.

My Action: Put her name on more waiting lists.

Prospect: Poor chance of moving her, if any at all

Thur., 6/27/85

Occasion: Telephoning nursing homes

Results: No luck. But official at Home "A" took the time to speak to me about Mom's sores. She said a culture on them is necessary to determine the type of infection. She said it was her experience that the sores alone could be causing Mom's persistent low-grade temp. and they could be difficult to heal without knowing what specific direction to take with medication.

Occasion: Telephone call from the office Manager, Health Care, before 5 p.m. requesting permission to pay Hannah without a signed time slip. Nursing Home staff refuses to sign hers any longer. They claim she is cheating me on the time she spends. Because Hannah has two hours of bus travel and a long wait between buses, I have told her that she may adjust her hours to any hours that cover the midday meal and I have no objection to her even leaving early to catch a bus, provided she has completed her tasks for the day.

My Action: I agreed to accept time slips unsigned.

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Fri., 6/28/85

Occasion: Routine visit

My Action: Decided to go talk to Nursing Home Administrator about the poor care Mom receives and the lack of staff cooperation with the aide I hired.

Findings: Administrator was out. This time I believe it is so because the door to her office is locked and there is no light coming from inside. Have tried to go in to talk to her before and found her door locked and the light on. No one answers my knock. It is said that she locks her door when she is in so that family members cannot come in her office. At approx. 2:30 p.m., two aides were just cleaning Mom up for the day. That process consisted of removing her smock, wiping the food off her face with it, brushing the crumbs of food off her neck and chest with it--period. The intake/output chart had run out yesterday. It had intake entries on one shift only on the 25th and 27th and output entries on two days during one shift of 50cc. The young nurse who told me a few weeks ago that Mom didn't need any attention to the three major infections on her foot, that it was inflamed and swollen because I insisted on getting her up out of bed, came in unwrapping a Tylenol suppository. She reported that Mom had a temp. of 102 F today and 101 F yesterday, but Mom had not been seen by the Dr's assistant nor had anyone called the Dr. to report her condition, nor had anyone notified me.

My Action: I expressed concern that Mom would be going into the weekend with an infection starting.

Nurs. Home Action: The nurse shrugged and refused to discuss it.

My Action: I requested that she change the bandages on Mom's legs because they were badly stained with new and old, dried drainage.

Nurs. Home Action: I was told she didn't have time. She had a medication order to call in and an admittance.

My Action: I insisted she either change them herself or leave a note for the next shift to do it. I persistently tried to get an answer as to whether or not the doctor had ever had a culture done on Mom's sores.

Nurs. Home Action: Nurse finally agreed to leave a note for next shift regarding bandages. After much evasion, she said that no culture had ever been ordered, and if the doctor had thought Mom needed one, he'd have ordered one. She informed me that the Nursing Home would not sign anymore time slips for Hannah--a new Nursing Home policy, she claimed.

My Action: I went to Dir. of Nurses and strongly complained that no one seemed to have any time for my mother, no time to bathe her, no time to order medication for her. Her needs seemed to come last in their line of priorities.

Nurs. Home Action: Dir. told me she would immediately call the doctor for medication and speak to him about a culture. She tried to tell me the aide was cheating me and didn't want to do her job.

My Action: I told her that has not been my experience. I hired the aide so that Mom could have additional care. I did not hire her to do what Nursing Home should be doing. I asked when her staffing problems would be solved.

Nurs. Home Action: Dir. said Nursing Home is fully staffed now. But when I told her that I was glad because now I could stop the private aide service, she advised me not to do that, to wait a while longer. She advised me that the nurse who was so rude to me and uncooperative was leaving their employ in two days. She said she would talk to the nursing staff to try to improve Mom's care.

My Action: Spoke later by phone with Dir. of Nursing, she had requested medication for Mom and spoken to the Dr. about the culture, but she was evasive when I tried to determine just what the Dr. had said about having a culture done. I was unable to get a satisfactory answer.

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Sat., 6/29/85

Occasion: Hannah called in sick. is trying to find someone who will come in tomorrow.

Sun., 6/30/85

Occasion: Called three times trying to check on Mom's condition but kept getting cut off when they tried to transfer the call.

Tue., 7/2/85

Occasion: Routine visit

Findings: Hannah was with Mom but could not bathe her because Mom was ill. She had diarrhea, probably from the antibiotics, the nurse said. Mom's condition appeared somewhat improved, but there were flies all over her. Someone splashed brown liquid all over the wall to a height of about eight feet, then left it to dry. The elevator smells like decaying matter.

Thur., 7/4/85

Occasion: Routine visit

Findings: Mom still has diarrhea. She was up and somewhat cleaned up, hair combed, hand was unattended. She has a fungus infection in her mouth again.

My Action: Brought in some kefir for Mom to drink. It is often used for children who experience diarrhea when taking antibiotics, I am told. Bill asked the nurse to please order something for Mom's mouth infection.

Nurs. Home Action: Nurse noted to request medication for mouth infection, something is already being administered for diarrhea.

Wed., 7/10/85

Occasion: Routine visit

Findings: Mom looks unkempt and has food all over her. She is still holding scrambled eggs in her mouth from an earlier meal. No staff visible on floor.

My Action: Cleaned Mom up the best I could but left the furniture and windowsill dirty.

Nurs. Home Action: none observed

Sat., 7/13/85

Occasion: routine visit

Findings: Nurse who was supposed to have been leaving in two days last month, according to the Dir. of Nurses, was charge nurse. The room was exceptionally dirty. The fly infestation terrible. Mom was in a mess from diarrhea. An aide complained that Mom's Kelly aide had not been in all week and they "had to do everything" for Mom. The Kelly Health Care aide is no longer showing up regularly.

Nurs. Home Action: Cleaning person came in to clean the room, left tables dirty.

My Action: Routine cleaning of Mom and room. Bill put garbage from tables on floor she was about to do so that it would be sweeped up. Bill and I purchased fly paper and hung some in the room.

Nurs. Home Action: The cleaning person returned and mopped around the garbage, leaving it on the floor, and she wiped away the weeks old spider webs on the windowsill.

Mon., 7/15/85

Occasion: Phone call and routine visit

Findings: Charge nurse said private aide did not show up for last assignment. She raved so profusely about how well the aide cared for Mom that it became obvious that she was trying to convince me not to be angry with the aide service and continue to have the private aide care for Mom. She stated that she would not have time to change Mom's bandages without the aide preparing her first. She said the complete process of removing the old bandages and cleaning the wounds took approximately 45 minutes and she did not have that much time to spend on one patient.

My Action: I agreed to continue the aide service.

Wed., 7/17/85

Occasion: routine visit

Findings: Mom was being returned to bed by a new aide. Mom was in some pain as I have frequently noticed after her sores are medicated and bandaged. The aide had been told not to wash Mom's hair because there was no shampoo, though a large bottle of shampoo is on Mom's nightstand. The room is dirty. The aide complained that no ice was available; I have not seen any ice in the pitchers in months. The nurse reported that Mom's temp. has finally gone completely. Her sores are healing nicely.

My Action: Asked aide to request Tylenol any time she sees Mom in discomfort after her sores are treated. Requested Tylenol from the charge nurse. I pointed out to the aide and nurse that the large bottle of shampoo that I had provided for Mom had been there all the while. I requested cooperation with the new aide from the Nursing Home staff.

Nurs. Home Action: The nurse repeatedly tried to change the subject and refused to discuss cooperating when I persisted. She administered Tylenol.

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Sat., 7/20/85

Occasion: routine visit

Findings: New aide today. Mom was just being removed from Whirlpool. She looked very well and was alert, pleased to see me, smiled. The room was a mess.

Wed., 7/24/85

Occasion: 10 p.m. Received call from chg. nurse Mom is very sick, having difficulty breathing, may not live through the night

My Action: Left immediately for Nursing Home.

Findings: Mom has no temp. but has heavy chest congestion. Pulse difficult to find, then very rapid and irregular. She is struggling very hard to breathe and moaning with her labor between breaths. She is completely unresponsive and on oxygen. She appeared clean and so did her bed. She refuses all liquids and food.

My Action: Try to make her comfortable

Nurs. Home Action: Appropriate only

Thur., 7/25/85

Occasion: visit, illness

Findings: Mom looks the same to me. Her breathing is just as labored, but her pulse is somewhat stronger and more regular. Mom looks clean and so does her bedding.

My Action: Same as yesterday.

Nurs. Home Action: Charge nurse an agency nurse, not staff, was extremely caring and sympathetic.

Fri., 7/26/85

Occasion: visit, illness

Findings: Mom doing very poorly. She looks grayish, eyes red and swollen. Seems to be struggling harder to breathe. She is very lifeless. There are flies walking all over her face and eyes and mouth. It is horrible. Her lips are dry. She still is taking nothing, food nor liquid. Her pulse unstable.

My Action: Talk to doctor, notify family, speak to funeral home. Try unsuccessfully to find the other rolls of fly paper. Remove a smock from the closet and swing it around to keep the flies off her. Otherwise same as before. Later found fly paper and hung some above the bed.

Nurs. Home Action: Nurse from agency very helpful and comforting. She gave Mom some Demerol to make her more comfortable and stabilize her pulse.

Sat., 7/27/85

Occasion: visit, illness

Findings: Mom's left hand blue and her breathing very shallow. Eyes beginning to roll. She is clean and bed is clean.

My Action: Same as before

Nurs. Home Action: Nurses and aides attentive, sympathetic, and helpful

At approximately 9:45 a.m., Mom stopped breathing.

Chairman HEINZ. Ms. Doyle, thank you for your testimony. You are a very courageous woman to have testified, to have gone through as best you could what was a truly trying experience, going back over a number of years. And I think every member of this committee can truly identify with you and feels just wrenched apart by what you went through.

And I suppose the saddest part is that you are not the only person who is going through that. You obviously came into contact with a very substandard nursing home, one that was chronically so. And if you just multiply that by all the number of people in that nursing home, and then multiply that by 600 or 900, which is what our investigations show is the minimum number of chronically, grossly substandard nursing homes, and then just imagine that number of people like you who are going through what you have gone through, I think people begin to get a sense of the widespread nature of this problem.

Ms. Dowling.

STATEMENT OF PEGGY DOWLING, NAPA, CA

Ms. DOWLING. My grandmother was brought into an acute hospital after having a stroke in March 1985. She was there approximately 3 weeks when they told us they could do nothing more for her and that we would have to move her into a convalescent hospital.

At that time, they said that if we did not find a place ourselves, that she would be moved into the first available bed in any hospital, convalescent hospital, in the State of California. We elected to bring her to Napa, where the family was, and we would be able to take care of her.

In looking for a convalescent hospital in Napa, we found out immediately that it was going to be very difficult. She had 60 days of Medicare to go before she would become Medicaid. That limited us to only three places, and only one of those we thought would be what we were looking for.

Soon after we transferred her to the hospital in Napa, we found her care to be very lacking. We would come in and find her not strapped into a wheelchair. Her left side was paralyzed, and her button for calling the nurse would be tied under the bed or underneath her left side, where she could not reach it.

The feeding of her by the aides, they would have one aide to about nine feeders, and they would shovel it in so fast that after two bites, she would quit eating. So we took it over ourselves, my mom and my sister and I; they did lunch; I did dinner after I got off work. And then we went in at least two other times during the day.

On the night of July 12, Gram showed a change in her health. She began having stomach cramps and vomiting and would not eat. My mother voiced to the nurse that she thought the doctor should be called. On July 13, she was much worse. They assured us that they would do that. They would have to take her vital signs first, and then they would call the doctor.

On Sunday morning, July 14, my mother went in to see her, and she was almost comatose. She was in extremely bad pain. My mom

came home very upset, and said they had not called the doctor, and it did not look like they were going to call the doctor. So I did it myself. He ordered an ambulance at 12:55 p.m. She died within hours.

We were afraid to complain about her care during the time because we were told that if we did, she would be moved to the back room or the back section of the hospital, which was the worst.

At the hospital before she died, her doctor told us that we had reason to complain, that her condition should not have been that way, and to please complain about it.

We contacted the ombudsman, who told me about their program. I had not known about it before. If I had, I would have been in there months before this happened.

And then we went into the Ombudsman Program in Napa. They contacted the State Office of Facilities Licensing and Certification, where we filed the complaint. They came in. They did an investigation and closed it within 10 days—or, excuse me, in the appropriate time that they had, and I asked how long that was and was quoted 10 days to do the investigation.

I was really disappointed and upset when only a "B" violation was given, and the nursing home was fined $1,000, and they closed the case. I did not accept it. I contacted the Ombudsman Program again. They contacted the State Justice Department and somehow got the case reopened. Further investigation indicated to the State that my grandmother's death would not have occurred had the nurse called the doctor when they should have, and the violation was then raised to a "AA" citation, which was a fine of $25,000.

Until I was contacted by the Ombudsman Program in January of this year, I had not heard anything more from the State on their actions, what was being done with my case. In January, they asked me to write a statement to the State Little Hoover Commission in Sacramento, CA, which I did. Approximately 3 weeks later, I got a letter from the State Office of Facilities Licensing and Certification, assuring me that they would keep me informed of all investigations or anything further that went on with my case. They have not done that. I have not heard anything more at all, until I was contacted to come back here and voice what happened.

[The statement of Ms. Dowling follows:]

Testimony of

PEGGY DOWLING

before the

U.S. SENATE SPECIAL COMMITTEE ON AGING

May 21, 1986

My grandmother was brought to an acute hospital when she had her stroke. She was there for several weeks when we found out she had to be moved to a convalescent home because the hospital could not do anything more for her. The hospital told us that she would be moved to the first available bed in any nursing home in the state of California. We asked if we could bring her to Napa where the family lived. They said it would be okay if we could find a place.

In looking for a convalescent hospital in Napa, we immediately found out that we were very limited in available facilities because Gram was a Medicare patient. She had approximately 60 days of Medicare left and then she was going to be put on Medicaid.

Soon after we got Gram transferred to the convalescent hospital in Napa, we found out that her care was not what we thought it should be. My mother, sister and I worked out a routine that would allow them to feed her lunch and I would feed her dinner after I got off work. We also stopped in the early morning and afternoon to visit with her. Often we would find her restraining strap holding her up with her paralyzed arm hanging over the side of the chair onto the floor. Sometimes her call button was put on her paralyzed side or tied underneath her bed. When my mother voiced her concern to the aides, they told her not to complain because Gram would be transferred to the back section and it was the worst. Because we were afraid to complain, we took on more and more care of Gram ourselves.

On the night of July 12, 1985, Gram showed a change in her health. She started to have stomach cramps and didn't want to eat. On July 13th, her condition worsened. My mother asked the nurse to call the doctor. The nurse told her that she could not call the doctor until Gram's vital signs were checked. She assured us that this would be done on each shift and the doctor would be called when it appeared necessary. On Sunday, July 14th, my mother went in to visit Gram. She came home upset. She said Gram was in extreme pain and that they had not called the doctor and it looked like they weren't going to. I called the doctor immediately myself and he had an ambulance sent to bring her into emergency. This happened around 12:55 p.m. Within two hours, Gram died.

After Gram's doctor saw her in the emergency room, he suggested we had reason to complain to the Ombudsman program about Gram's care in the rest home. My mother and I went into the Napa office two days after Gram died. They contacted the state Office of Facilities Licensing and Certification who did an investigation into her death. I was really disappointed and upset when I found out the state had issued only a "B" citation to the rest home and the case had been closed. The inspector for the State of California told me that in the time allowed for investigations, her findings did not warrant a "AA" citation. I asked how much time was allowed and was told 10 days. Again, I spoke to my contact in the Ombudsman office who contacted the State Justice Department. I feel strongly that because of their involvement, questions were raised about the "B" citation. The result was that the case was reopened and more evidence was found. The "B" citation was raised to a "AA" citation, and the fine was increased from $1,000 to $25,000.

Until I was contacted by the Ombudsman in January, 1986, I hadn't heard anything more about the State's actions since the previous August. When I was contacted, I was asked to present a statement to the State Little Hoover Commission, an investigative panel, about Gram's death. Approximately three weeks after submitting my statement, I received a letter from the State Licensing and Certification Office assuring me that I would be kept up-to-date on Gram's case. I haven't heard anything more from the state since then.

OMBUDSMAN PROGRAM

VOLUNTEER CENTER OF NAPA COUNTY, Inc.

1700 2ND ST., SUITE 308
NAPA, CALIFORNIA 94559 (707) 252-6222

July 16, 1985

TO : Licensing & Certification
FROM: Kristin Casey, Napa County Ombudsman Program
RE : Complaint against Convalescent

My office was contacted by phone yesterday at 400 PM, by Betty , daughter of Anna . Anna had been a patient at from March 22 to July 14, when she passed away. Mrs. and her daughter feel that was negligent in the care her mother received the last two days of her life, and that Mrs. suffered needlessly and perhaps died unnecessarily, due to lack of adequate nursing care and judgment.

Mrs. statement follows:

Saturday, July 13, 1985--NOON

We got there around noon to give ma her lunch and she said that she had thrown up that morning and didn't want to eat anything. The nurse came in with her pills and I told the nurse that ma's stomach hurt and she didn't want to eat. The nurse gave her her pills and the Milantin.

I told the nurse that ma felt cold and clammy, which is how she feels when she hurts. The nurse felt her forehead and said that it was just because her hair was wet from washing. She didn't take her temperature or anything, but she said ma's vitals were normal that morning and that they would take her vitals every shift change.

I also told the nurse that 10 years ago my ma had had heart failure and when the dr. released her from the hospital he said that if she ever got sick to her stomach don't ignore it and never assume that it was a bug, that he wanted to know immediately if something like that happened. So I let her know that the throwing up was not normal with my mother, and that her old doctor had said it was too important to ignore. The nurse didn't say anything about that, but just said the Milantin might help, and then she left the room.

continued (p. 2)

Saturday, July 13--5:15 PM

We went back to give ma her dinner, and she didn't want to eat anything still. When the nurse came in with her pills that night, I told her ma couldn't eat because of cramps in her stomach. The nurse said that ma was having sherbet for dinner, and maybe that would be good for her. I asked the nurse if she couldn't give ma something for the cramps. The nurse gave ma her pain pill, her other pills, and said maybe the Milantin would help.

My mother said that she was in awful pain and she didn't know why she had to hurt like this. I told her I didn't know why either. Ma said that if she ate she would throw up, and I again told the nurse that that was very unusual for ma. The nurse didn't answer that. The nurse was busy keeping track of a wandering patient, so she couldn't stay long in our room. It didn't seem like this nurse knew anything about what I had said about ma's problems to the day nurse--my concerns didn't seem like they were important, and I was beginning to feel as if I was being overprotective, because no one was responding to my worries.

The nurse did say she would keep her eye on ma, and that she would be there until 11:30. I assumed that the nurses would know to call ma's doctor if she was taking a turn for the worse or if she needed a doctor.

Sunday, July 14, 1985--before 9:00 AM

see addendum *

We continued to be worried about ma, so my daughter, Peggy, decided to call to see how she was. The nurse told Peggy that ma was fine and that she was better this morning. The nurse said that she ate her breakfast but threw it up. When Peggy got off the phone she was angry and said to me, "The damn fools--how can she be better if she's throwing up?" So I decided to go in and see ma for myself, before I had to go to San Rafael.

Sunday, July 14--9:15 AM

We went to and went into ma's room. She was laying there kind of limp and her face looked all sunk in and she had trouble talking--her speech was noticeably slurred. My other daughter, Donna, said to ma that she sounded like she needed a drink and she gave her a sip of water, which seemed like it helped her a little. Her aide was very nice and was brushing her hair when we got there. The aide said "I'm so worried about your mother"--she said she was worried both yesterday and today.

cont. (p. 3)

I went out to the desk then to talk to the nurse, an LVN. I told her that I thought my mother was quite sick and I again pointed out that she was cold and clammy. I said she still was having stomach pains and cramps, and I said I thought they ought to call the doctor. The nurse said she couldn't call the doctor until ma's vitals were taken. And I said "haven't they been taken?' She said they hadn't been taken since Saturday morning. I said they told me they would take the vitals every shift change, but apparently they hadn't. And that was it. She just stood there staring at me. She wouldn't call the doctor until they took the vitals.

I went back into ma's room and she said again, "I don't see why I have to hurt like this. We talked to her awhile, and I told her my other daughter, Peggy, would be in to see her after we had to leave.

We went home and I asked Peggy to go in and take her husband with her, becuase I felt something was very wrong. Peggy decided not to take any more time to go in, and she called Dr. immediately. Dr. called Peggy back around 11:00 AM. Peggy told him that she was frustrated because would not call him and the family felt he should have been called on Saturday. Peggy told the dr. that we were afraid ma had had another stroke and he asked what made us think that. We told him because her face was sunk in and her speech was slurred and she was cold and clammy and had been throwing up. He had ma sent to emergency at so that he could examine her.

Sunday, July 14--11:45 AM

Peggy's account, at QVH: I got to the about quarter to twelve. Anna had not been brought in, so I called the facility around 12.40 to see if she was on her way yet. A girl named Terry answered the phone, and I said "hi Terry, has the ambulance come to pick up Anna yet?" She asked, "Who is this?" I said "Anna 's granddaughter, Peggy She said, "No, we're waiting", and she hung up. The way she hung up, I felt that they knew they had done something wrong.

When the ambulance brought gram in, I said "Gram, this is Peggy" but she didn't answer me, she just lay there--she wasn't coherent, her eyes were moving back andforth and she was breathing really heavy. My husband,David, came over and I yelled louder at her that it was Peggy and David. She still could not answer, and I started to cry. I asked David why they would let her get in this shape without calling the doctor for help. David told me to get myself under control, so I walked away. I went back over to her after a moment and I again yelled "Grandma" at her. This time she just made a sound like "uhh".

cont. (p. 4)

(Peggy's account at QVH):

At that point they took gram in, and I called my mom to come up from San Rafael because of how bad gram was. On my way to the phone, the medics from Ambulance Service stopped me and asked if I was Anna 's granddaughter and I said yes. The medic said "I know you're upset but I feel you should know that when we got there to pick her up, the nurse wasn't very cooperative." He said that he had to verbally and using his fingers get her to tell him anything. He asked the nurse what was wrong with gram, and she replied "She's always like this". I said she was not always like this, that she's usually alert and her mind is quite good, even though she's 92. Then he said he asked the nurse what gram was being treated for at , and he went through a list of things: Heart trouble, stroke, diabetes. The nurse answered yes on the diabetes and he asked her if gram was given insulin. The nurse said yes, she was given her insulin on both Saturday and Sunday. The medic thought gram might be suffering from a diabetic coma, from what he could get out of the nurse at . He asked what she had eaten. He told me it was like pulling teeth to get any information from about gram's condition. He was very upset, and seemed to know that I had called the doctor, that the facility had not.

When I went back in, they let us go in to be with gram. I could feel that the doctor was concerned about the condition that she'd been brought in. Gram was more alert now, but she couldn't talk. We were told that she was dehydrated.

Around 3:00, the doctor took the family into the conference room and he explained that he felt that this was something fatal, that she had a blockage of some kind. Donna asked Dr. if had called him, and he said he had received no other phone calls regarding our grandmother besides the call from me. He said he felt things had not been handled as they should and we had reason to raise a complaint, and that we should talk to the administrator and also call the Ombudsman Program. He also questioned us about the insulin, because the nurse had said she took insulin and he knew she was not on insulin at all. Dr. said he was going to admit gram into the hospital.

Gram died within about an hour of our talk with Dr. . We feel that all this suffering that she went through was not necessary, if the facility had been more attentive to her change in condition and if they had listened to the family instead of ignoring us.

Monday, July 15, 1985--11:15 AM

Peggy's account of meeting with Administrator and Director of Nurses: We went into Betty s office because I told her I wanted to talk to her about the handling of my grandmother, Anna . She said "She was transferred." Then I said "She died last night." The administrator just

cont. (p. 5)

looked at me and said nothing. I asked her to tell me the proper procedure that the nurses were to use when the family requested that a doctor be called. She did not answer me. She picked up her loudspeaker and sternly requested that Lynn to come to the administrator's office. She announced that twice. I then asked her why the nurse would tell the medics that my grandmother was given insulin when she wasn't on it. At that point she got up and said "I'll go and get the records." She came back in with the chart and opened it up and said there wasn't anything about insulin in it. She said didn't understand why they would have given her the Milantin when she had stomach cramps and was throwing up. I told her I felt that the last 3 days of care for my grandmother was the pits. She then again picked up the loudspeaker and called for Lynn to come to her office. I asked her why they would feed her oatmeal and eggs for breakfast when she was throwing up. She said "I don't know".

When Lynn came in she said to my mother, "I'm so sorry about your mother"--it sounded phony. Betty turned to her and said that we were there becasue we were unhappy about the circumstances surrounding gram's last 3 days of care. Lynn turned to mymother at stated that my grandmother was always having pains and mymother responded that all she had to do was look at gram to tell that something was wrong, and she does not even have medical training. Lynn then gave the excuse that the nurse had "just been hired." I said I hoped she had been able to speak and read English in order to be in this position; I also said I saw that they have a high employee turnover at . They acted like I hadn't said anything. Lynn again stated that the nurse was new. I again brought up the question of why the nurse should tell the medic that my grandmother was given insulin when it wasn't true. Betty said, "If the nurse said that." I responded with "The medic had a clipboard with his questionnaire and the nurse's answers, which he gave to Dr. ". And Lynn said yes, that she had spoken with Dr. that morning. I again asked why gram was given oatmeal and eggs after having thrown up all day Saturday. Betty said she only threw up after she ate, so it was only three times. My stated, "She only eats three meals a day, and she threw all of them up." I said anyone should know that if she was throwing up all her food, she should be given liquids. Then I asked for the name of the nurse; Lynn hesitated and looked at Betty and asked her if she should give me the name and Betty replied yes. She gave me the name of . They could not give me her employment date. Lynn also made a point of saying she was the "weekend nurse" and again added that she's new. I said I was not going to accept the exouse that the nurse was new; we also feel that there is no excuse to have less than competent nurses scheduled on weekends.

cont. (p. 6)

LYnn stated that she would be working with Dr. on the investigation. I said I wanted a copy of everything in writing that came from the investigation, and I wanted to be updated on it at all times. As we left, I asked the administrator if she is the last one to know what happens around this place, because this was the first she'd heard of all this. She replied, "Apparently". Lynn replied "Only on weekends." At this point it was noon on Monday, and I said to Betty, "That's too bad."

I just want to add that gram always held on to the idea of living to be 100. Hardly any day went by that she didn't mention the cake that Mike was going to make for her on her 100th birthday. She always said she would hold him to it.

* Addendum concerning Peggy's call to on Sunday, July 14:

When I called that Sunday morning, I told the girl who answered who I was and said I wanted to know how my grandmother was. The receptionist went and got a nurse for me. It was hard to understand the nurse, because she was oriental. The nurse said gram threw up all day Saturday, seemed to be better Saturday night, but this AM was throwing up again after they fed her breakfast. And then she hung up.

* Addendum from Mrs. concerning Sunday AM:

The cook from the kitchen came be and asked how my mother was, and I told her she was ill and throwing up and she couldn't eat the food. She said she didn't know that, and if they had told her, she would have sent her liquids to eat.

SECTION 1424 NOTICE SUPPLE T -03

This form is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	72311(f)(B) - continued		
	6-23 1000 am ..."changed foley, no out put on noc..."		
	6-23 ..."very poor I & O general condition poor"		
	6-30 ...."Foley patient but with only 75 cc output the whole shift".		
	On July 1 the patient was transferred to acute care.		
	FAILURE TO NOTIFY THE ATTENDING PHYSICIAN PROMPTLY OF ANY SUDDEN AND/OR MARKED ADVERSE CHANGE IN SIGNS, SYMPTOMS OR BEHAVIOUR EXHIBITED BY A PATIENT HAS A DIRECT OR IMMEDIATE RELATIONSHIP TO THE HEALTH, SAFETY OR SECURITY OF THESE PATIENTS AND ALL THE PATIENTS IN THE FACILITY.		
01H-233-032	CLASS "B" VIOLATION		
72311(f)(B)	Nursing Service - General	$1,000.00	0900
	Nursing service shall include, but not be limited to, the following: Notifying the attending physician promptly of: any sudden and/or marked adverse changes in signs, symptoms or behaviour exhibited by a patient:		7-30-85
	Patient "B" is a 92 year old female admitted to the facility 3-22-85 with diagnosis of s/p C.V.A. - diabetes - L hemiparesis. The medical record documentation of licensed nurses July 13 & 14 was reviewed.		

Name of Evaluator Toni Stratton, HFR-N

Signature of Evaluator Toni Stratton

State Department of Health Services
Licensing and Certification Division
50 D Street, Suite 330
Santa Rosa, CA 95404-4738

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice.

Signature Adm.

Name

Title Administrator

HS 816A1 (4/85)

HEALTH CARE FINANCING ADMINISTRATION
MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER NUMBER: 05-	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED: 7-23-85

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Convalescent Hospital	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED 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
F128	Citation # 018-233-032 X-Ref Complaint # 8855-118-SB 72311(3)(B) 405.1124(c) Patient "B" is a 92 year old female admitted to the facility 3-22-85 with diagnosis of S/P C.V.A., diabetes, L hemiparesis. The medical record documentation of licensed nurses July 13 and 14 was reviewed. 7-13 "... had emesis x2 of previously taken food..." 3 PM later note "... didn't eat her food only took fluids..." 7/14 10 AM "... emesis x1 after lunch with complaint of mild abdominal pain and clammy perspiration..." There was no documentation the physician was called. The patient was transferred to the acute hospital 7-14-85 at 1255 where she expired a few hours later.	F128	F126 1. All licensed nurses will be in-serviced on proper nursing assessment skills. 2. The policy and procedure on timely notification of physicians will be reviewed with all nurses. 3. The Nursing Care Coordinator will review skills of all new licensed staff oriented within one month of hire. 4. Responsible nurses for untimely notification will be disciplined as appropriate.	07-28-85 07-28-85 07-23-85 07-28-85

APPROVED BY STATE CERTIFYING AGENCY ☐	REVIEWED BY (INITIALS)	DATE	PROVIDER REPRESENTATIVE'S SIGNATURE	RE DATE
DISAPPROVED BY STATE CERTIFYING AGENCY ☐				07-24-85
APPROVED BY OHHS REGIONAL OFFICE ☐	REVIEWED BY (INITIALS)	DATE	TITLE	
DISAPPROVED BY OHHS REGIONAL OFFICE ☐			Administrator	

(MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.)

* Any deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients.
(See reverse for further instructions.)

Form HCFA-2567(11-80) (Formerly SSA-2567) 4 SURVEY STATE AGENCY Page ___ of ___

SECTION 1424 NOTICE SUPPLE T Violation ation Number(s): 32

This form is used as a Supplement to the Section 1424 Notice (HS 816). When the violations cannot all be listed on the notice, this form is used for additional pages.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	72311(3)(B) - continued		
	7-13 ..." had emeses x2 of previously taken food..."		
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	The patient was transferred to the acute hospital 7-14-85 at 1255 where she expired a few hours later.		
	FAILURE TO NOTIFY THE ATTENDING PHYSICIAN PROMPTLY OF ANY SUDDEN AND/OR MARKED ADVERSE CHANGE IN SIGNS, SYMPTOMS OR BEHAVIOUR EXHIBITED BY A PATIENT HAS A DIRECT OR IMMEDIATE RELATIONSHIP TO THE HEALTH, SAFETY OR SECURITY OF THESE PATIENTS AND ALL THE PATIENTS IN THE FACILITY.		

Name of Evaluator Toni Stratton, HFR-N

Signature of Evaluator Toni Stratton

State Department of Health Services
Licensing and Certification Division
50 D Street, Suite 330
Santa Rosa, CA 95404-4738

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice.

Signature [illegible] Asm

Name [illegible]

Title Administrator

HS 816Ai (4/85)

OMBUDSMAN PROGRAM
VOLUNTEER CENTER OF NAPA COUNTY, Inc.
1700 2ND ST., SUITE 308
NAPA, CALIFORNIA 94559 (707) 252-8222

August 22, 1985

Donald J. Yannetta
Regional Administrator
Department of Health Services
Licensing & Certification
2422 Arden Way, Bld. B, Suite 35
Sacramento, CA 95825

Dear Don,

I would like your guidance and help with an issue which is causing me grave concern. In regard to complaints against Convalescent Hospital in I have perceived a lack of an enforcement orientation by the Santa Rosa Licensing office, which we depend upon for back-up in relation to potentially serious complaints.

My immediate concern involves a complaint which I received on July 15, 1985 and referred on to Licensing the same day.

I would like to here present a chronology of events as I have perceived them, so that you may better understand my frustration:

July 15, 1985

Betty , daughter of patient Anna , called the Ombudsman office with a complaint about poor nursing care and negligence at Convalescent Hospital. The family feels that their mother's suffering and death are related to negligence and lack of response to their concerns, by the facility. Licensing notified by phone from Ombudsman office.

July 16, 1985

Deceased patient's daughters came to Ombudsman office, and I typed their statements verbatim. Please see enclosed statement.

L&C evaluator, Toni Stratton, returned our call and agreed to pick up complainants' statements next day.

Family informed me later that the patient's physician (and also the facility's Medical Director), Dr. , had refused to sign the patient's death certificate and requested an autopsy. The coroner's office performed the autopsy at 4:30 on Monday, July 15.

July 17, 1985

Toni Stratton, L&C evaluator, came by Ombudsman office, 9 AM, to pick up family's typed statement. She indicates is pursuing the investigation and will keep us informed. She said she wanted to be sure the investigation was thorough enough to uphold an "A" citation if the case warranted it.

July 23, 1985

Granddaughter of patient, Peggy Dowling, called: family was notified by the doctor that autopsy revealed an intestinal blockage. Family to get copy of autopsy report.

August 6, 1985

No feedback or further contact from Licensing concerning the case. I called L&C office because I was to go on vacation for 10 days beginning August 8, and I wanted to find out if a CRC would occur during my absence. I spoke with Mr. Shipley, administrator of the Santa Rosa office, who said that Licensing did find that the patient's doctor was not properly notified of the change in condition. He added that now they are thinking that the "B" citation issued by Toni Stratton should be changed to an "A".

This was the first I heard that this complaint was given only a "B" citation, and I immediately expressed my feeling that this had appeared to be much more serious issue than the "B" indicated. I was extremely surprised by this turn of events, especially since the evaluator and I had discussed the seriousness of the complaint.

Mr. Shipley said that he now felt that Toni may have looked at this case "too quickly", that she had not looked at all the reports (including the autopsy report) but that she will do so. He added that there was another very similar case occuring simultaneously, in which there was failure to report a patient's change of condition and in which the patient had expired (also a patient).

Mr. Shipley replied to my concern about missing a CRC between this date and August 19, that it was unlikely that it would come about that soon.

August 19, 1985

I returned from vacation to find a report from Licensing showing two "B" citations against and the notice of a CRC slated for August 15. Please see enclosed L&C reports.

My immediate reaction was to wonder why the same standards which seem to be in operation in other parts of the state (in which AA citations are being issued for very similar complaints) are apparently not being applied here.

August 21, 1985

I called Mr. Shipley, at Licensing, to ask why this case was so quickly determined to be only a "B" violation rather than an "A" or "AA".

In reference to my receipt of the "B" citation in the mail, Mr. Shipley said, "Something's happened since then." He explained how there were two cases which are very similar; one patient died the same day she went to the acute care hospital and the other died 4 days later. He said that in both cases, the doctor was not contacted by the facility when the patients exhibited unusual symptoms.

Mr. Shipley went on to say that two "B" citations were initially written. He then said that after writing the 2 B's the evaluator (Toni Stratton) received "additional information" about the cases, evidently from the ambulance drivers (whom Toni and I had discussed the need to interview) and from the ER room. Mr. Shipley said it was not until this "additional information" was uncovered that Licensing enlisted the services of their Physician Consultant. When I asked why the physician was not consulted with earlier, considering the seriousness of the complaint, he replied that the physician is not always available.

Mr. Shipley said that the reason the cases were originally set at a "B" level is because the evaluator had a difficult time relating the stated cause of death with the symptoms or with not notifying a doctor; but he added that now they feel these can be tied together.

I then asked why a more thorough investigation was not conducted before issuing the "B" citation, and mentioned that the evaluator and I had discussed the importance of talking with the ambulance drivers and getting all possible information in order to uphold a possible A or AA citation.

Mr. Shipley then said that they have "rescinded the B's, based on the new information, and have reopened the investigation." He added that they have yet to pull it all together, but that I would be notified of progress and results.

Mr. Yanetta, this is the most serious complaint I have forwarded to Licensing concerning Convalescent, but it is not the first time I have felt a reluctance to vigorously enforce regulations in this facility. In particular, eyewitness accounts by family members and friends of patients in this nursing home have historically not been given validity when they contradict what the facility administrative staff have to say.

I would welcome your involvement in this, and any advice you can give me concerning how to best work cooperatively with the Licensing agency to ensure protection of patients and adequate investigation of complaints made on their behalf.

Yours very truly,
Kristin Casey
Kristin Casey
Napa County Ombudsman Coordinator

cc: Esther Rains, State Ombudsman
Mary Hinchliff, CLCTOA President

Citation Ref Comp.

FORM APPROVED OMB NO 0938 0043

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: 05-

(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____

(X3) DATE SURVEY COMPLETED: 08/28/85

NAME OF PROVIDER OR SUPPLIER: Convalescent Hosp.

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED 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
F128	CLASS "AA" VIOLATION 405.1124(c) 72311(3)(b) Nursing Service-General Nursing service shall include, but not be limited to the following: Notifying the attending physician promptly of: any sudden and/or marked adverse changes in signs, symptoms or behaviour exhibited by a patient. Patient "A" was a 92 year old female patient admitted to the facility on 3-22-85 with the following diagnosis: s/p C.V.A. - diabetes - (L) hemiparesis. A review of the medical record between 7-12-85 and 7-14-85 documented marked adverse changes in the signs and symptoms of this patient. The patient was transferred to the acute hospital on 7-14-85 @ 1255 where she expired a few hours later.		Prep and execution of this Plan of Correction does not constitute an admission or agreement by this facility of the truth of the facts alleged or conclusions set forth on the statement of deficiencies and is being prepared and executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907. The facility has had and continues to have and follow a policy of notifying attending physicians promptly with respect to sudden and/or marked changes in patients. It will continue to inservice on periodic bases all staff with respect to the necessity of giving such timely notification. The last inservice for this was on July 28, 1985. We have and will continue to monitor the skills of staff to determine their knowledge of these requirements. The Nursing Coordinator will be responsible for this.	9/4/85

APPROVED BY STATE CERTIFYING AGENCY ☐
DISAPPROVED BY STATE CERTIFYING AGENCY ☐
REVIEWED BY (INITIALS) _____
DATE 9/30/85
PROVIDER REPRESENTATIVE'S SIGNATURE
(X6) DATE

APPROVED BY DHHS REGIONAL OFFICE ☐
DISAPPROVED BY DHHS REGIONAL OFFICE ☐
(MEDICAID ONLY FACILITIES REQUIRE NO RESPONSE IN THIS BLOCK.)
REVIEWED BY (INITIALS) _____
DATE
TITLE

* A deficiency statement ending with an asterisk (*) denotes a condition which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients.
(See reverse for further instructions.)

DHHS HCFA-2567(11-80) (Formerly SSA-2567) 4. SURVEY STATE AGENCY Page ___ of ___

Citation 9

Form Approved
OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Continuation Sheet	(X1) PROVIDER NUMBER 05-5332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 8/28/85

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY.)	(X5) COMPLETION DATE
	72311(3)(b) continued There was no documentation that the attending physician was notified of the marked, adverse signs and symptoms of this patient. The physician's review of the medical record and autopsy report of Patient "A" determined a direct proximate relationship between lack of physician notification and the patient's subsequont expiration.			

HCFA-2567A (12-75) (FORMERLY SSA-2567A)

4. SURVEY STATE AGENCY

Page _____ of _____

06

Violation or Citation Number(s): 010

You are hereby found in violation of California Health and Safety Code, Division 2 and/or California Administrative Code, Title 22, Div. 5

LICENSEE: Corporation

DATE: August 28 1985 TIME: 1530 0..

TYPE OF OWNERSHIP: Profit Corp. CAPACITY: TYPE OF VISIT: Complaint

FACILITY NAME: Convalescent Hospital

FACILITY ADDRESS (STREET): FACILITY TYPE: Skilled Nursing FACILITY NUMBER:

PHONE NUMBER:

Each citation will identify the code, title and section violated, the class of violation, the requirement of law or regulation, the nature and location of the violation and the time limit for correcting the violation.

Section	Class and Nature of Violations	Penalty Assessment	Deadline for Compliance
	CLASS "AA" VIOLATION	$25,000.00	
72311(a)(8)	NURSING SERVICE - GENERAL		0900
	Nursing service shall include, but not be		8-30-85
	limited to the following: Notifying the		
	attending physician promptly of: any sudden		
	and/or marked adverse changes in signs,		
	symptoms or behavior exhibited by a patient.		
	Patient "A" was a 92 year old female patient		
	admitted to the facility on 03-22-85 with the		
	following diagnosis: s/p C.V.A. - diabetes -		
	(L) hemiparesis. A review of the medical record		
	between 7-12-85 and 7-14-85 documented marked		
	adverse changes in the signs and symptoms of		
	this patient. The patient was transferred to		
	the acute hospital on 7-14-85 @ 1255 where she		
	expired a few hours later.		
	There was no documentation that the attending		
	physician was notified of the marked, adverse		
	signs and symptoms of this patient.		

Name of Evaluator: Toni Stratton HFR-N

Signature of Evaluator: T. Stratton

State Department of Health Services
Licensing and Certification Division
90 D Street, Suite 330
Santa Rosa, CA 95404-4758

Without admitting guilt, I hereby acknowledge receipt of the Citation Notice.

Signature:

Name:

Title: Adm. Asst.

NOTE: In accordance with California Health and Safety Code, failure to correct violations is grounds for suspension or revocation of your license.

HS 8161 (4/85)

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
3432 ARDEN WAY, BUILDING B
SUITE 38
SACRAMENTO, CA 95825
(916) 920-6651

September 4, 1985

Kristin Casey
Napa County Ombudsman Coordinator
1700 2nd Street, Suite 308
Napa, CA 94559

Dear Ms. Casey:

This is in response to your recent letter concerning complaints against the Convalescent Hospital in , and the Santa Rosa District Office.

As I indicated to you by phone, even before the receipt of your letter, I had already directed that the complaint and the "B" Citation be re-evaluated after it had come to my attention during my administrative review of the citation.

As further indicated to you, as a result of the re-evaluation, additional information and our Medical Consultant's review, the citation had been elevated from "B" to an "AA" Citation.

Please be assured that all complaints forwarded to the District Office will receive careful and thorough investigation and citations will be appropriately issued as the situation warrants.

You may be interested to know that the Division of Licensing and Certification has established a Program Review Team which has, as one of its responsibilities, the evaluation of District Office operations in order to assure that regulations and Department policies are interpretated uniformally statewide and to identify training needs. It is expected that the Santa Rosa District Office will be reviewed in the near future.

We look forward to your cooperation in assisting us to ensure that all patients in Health Facilities are protected.

Thank you for bringing your concerns to my attention. If I can be of further assistance, please contact me.

Sincerely,

Donald J. Yannetta
Regional Administrator
Licensing & Certification Division
Northern California Region

cc: Esther Rains, State Ombudsman

January 22, 1985

TO: Little Hoover Commision

FROM: Peggy Dowling

SUBJECT: Statement Regarding Facilities Licensing

My name is Peggy Dowling. In July of 1985 I had reason to file a complaint with the Napa County Ombudsman Program. My Grandmother was a patient in a local nursing home. I feel that the lack of physician notification of the change of her condition on July 12 & 13 resulted in her death on July 14, 1985. Her doctor agreed that a complaint should be filed.

On July 16, 1985 my Mother and I filed a complaint. On July 23, 1985 a "B" citation was issued and the case was closed. I felt that the nursing home had only had their hands slapped.

I spoke with the evaluator within a few days of the citation being issued. I was told "In the time allowed for the investigation my findings did not warrant a "AA" citation. I asked how much time was allowed? I was quoted "10 days".

In the next couple of weeks during my telephone conversations with the evaluator, I certainly got the impression that she didn't feel good about the citation not being higher. I also got the impression that she felt it was out of her hands.

When I filed my complaint with the Ombudsman, a copy was sent to the Justice Dept. I feel strongly that because of this involvement questions were raised about the "B" citation. The result was the case was reopened and more evidence was found and the "B" citation was raised to a "AA" citation.

I'm glad about the outcome of this, but I have a concern about the time limit for the investigation. In my case 10 days just wasn't enough time. It resulted in a incomplete investigation and a lower citation then was warranted. My remaining concern is that I haven't heard anything from State Licensing since August 8, 1985. I have no idea where the case stands, when or if it will ever go to court, and more importantly if the nursing home will ever have to pay the fine. The nursing homes need the laws to be enforced to insure proper care for the elderly. Thank you.

Sincerely,

Peggy Dowling

Peggy Dowling
5266 Old Sonoma Rd
Napa, CA 94557

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

(916) 322-9193

Ms. Peggy Dowling
5265 Old Sonoma Road
Napa, CA 94558

Dear Ms. Dowling:

This is in response to your letter of January 22, 1986, addressed to the "Little Hoover Commission", and the concerns you expressed regarding the investigation of your grandmother's death.

Please accept our apology for not keeping you informed of the current status of the investigation involving your complaint against Convalescent Hospital.

I have requested Erv Shipley, District Administrator of the Santa Rosa District Office, to send you copies of the Statement of Deficiencies on the "AA" citation that was issued to the facility regarding the death of your grandmother.

If you have further questions, please do not hesitate to contact Mr. Shipley at the Santa Rosa District Office, 50 D Street, Room 330, Santa Rosa, CA 95404, (707) 576-2380.

Sincerely,

Paul H. Keller, Chief
Field Operations Branch
Licensing and Certification

cc: Erv Shipley
Santa Rosa District Office

K. Casey
Napa County Ombudsman
Coordinator

Chairman HEINZ. Ms. Dowling, first we thank you for coming back here. It is a long way from Napa, either Sacramento or San Francisco, to come back to Washington, DC. And it is particularly hard under the circumstances that you have described you were experiencing and still obviously are very much feeling the effects of. You are a courageous woman to do that.

Ms. DOWLING. Thank you. This is for Gram. I have to say I am doing this for Gram.

Chairman HEINZ. I am also sure that your two California Senators, Pete Wilson and Alan Cranston, will be very much interested in this situation and will want to assist you in pursuing it with the appropriate State authorities.

There is one other matter that concerns me also about your case. You did mention that the citation had been upgraded to "AA" and a $25,000 fine. We checked into that, and we find that that fine is yet to be collected from that nursing home.

Ms. DOWLING. They told us that they would appeal it, and it would go into a court in Napa. When I asked when, I was told it could be any time within a year, 2 years.

Chairman HEINZ. So you are aware of the fact that the fine is still in the pockets of the nursing home.

Ms. DOWLING. That is why I keep in very close contact with the Ombudsman Program.

Chairman HEINZ. You know, these are often kind of cold statistics up there, behind Senator Nickles and Senator Cohen, when it says, "Facility failed to provide adequate physician supervision of patients," or "Facility failed to provide adequate 24-hour nursing care," and that is where you have a nurse that knows what is going on. And apparently, in your case, that was not at all the situation. Those statistics take on very real, live, flesh-and-blood meaning.

Ms. DOWLING. Senator Heinz, I would like to say something. The day after my grandmother died, I went back to the convalescent hospital and asked them what their procedure was on calling a doctor when it became apparent that it was necessary. The excuse I was given was that the nurse was "new, and only a weekend nurse".

So I agree with Senator Pryor—after hours and on weekends, the things that go on—and they do know when the evaluators are coming. As soon as we walked in the door, we could tell. Everybody had their restraining belts on; they were clean; people were bustling around, looked busy.

Chairman HEINZ. And it is probably true that the best staff, the most experienced staff, the most senior staff, would rather work during the day than on the night shift or the graveyard shift.

Ms. DOWLING. Yes.

Chairman HEINZ. Thank you very much, Ms. Dowling.

Senator PRYOR. May I make a comment, Mr. Chairman?

Chairman HEINZ. By all means.

Senator PRYOR. Ms. Dowling has really underlined a problem of so many nursing home patients, and the families especially, and that is the absolute fear of registering a complaint because of repercussions or reprimands against the patient if a complaint is raised. I hope that Dr. Roper is listening to this, because that in

itself is one of the more grave problems that we have. It is a serious issue, that is absolute fear, because the nursing home can turn you out, they can put you in, as you say, another part of the facility. They can do many, many things to you, and no one will know about it.

I appreciate your bringing that point up, because that problem certainly exists.

Thank you, Mr. Chairman.

Chairman HEINZ. Thank you, Senator Pryor.

Senator NICKLES. Mr. Chairman.

Chairman HEINZ. Senator Nickles, by all means. Just let me explain.

Senator NICKLES. I hear you.

Chairman HEINZ. I wanted to go through the panel of witnesses now, but if you have a comment or an opening statement——

STATEMENT BY SENATOR DON NICKLES

Senator NICKLES. If you do not mind, I do not have any questions for the panelists, and I apologize for the fact that we are having an energy markup, and my staff is telling me they need me to scout. So I want to congratulate you and compliment you on having this hearing. I think the additional focus and exposure, if nothing else, will hopefully highlight some of the problems and help bring about enough pressure throughout the country.

I think the statistics that you have shown on the chart indicate that we do have a problem throughout the country. So I compliment you for it, and maybe with enough exposure, pressure, and attention focused on the problem, we can help improve the quality of health care throughout a lot of the nursing homes throughout the country.

So I compliment you for the hearing, and I apologize for the fact that I need to excuse myself.

Chairman HEINZ. Senator Nickles, thank you very much for joining us.

Let me call on our next witness, Mr. Ralph Lopez, who runs a very aggressive nursing home compliance program, I am told, in Los Angeles. He will offer as part of his testimony a videotape—that is why we have these monitors—and I know that that videotape documents some really shocking conditions inside nursing homes in Los Angeles County.

Mr. Lopez, please proceed.

STATEMENT OF RALPH LOPEZ, CHIEF, HEALTH FACILITIES DIVISION, COUNTY DEPARTMENT OF HEALTH SERVICES, LOS ANGELES, CA

Mr. LOPEZ. Good morning, Senator Heinz.

I am Ralph Lopez, chief of the health facilities division for Los Angeles County. The health facilities division is responsible for the inspection of health facilities and other various ancillary services for State licensure.

As a representative of the State agency, we also inspect providers for compliance with Medicare and Medicaid regulations for the appropriate Federal agency.

I have been involved in these programs for the last 20 years, first as a surveyor since the inception of Medicare in 1966; then, as a district supervisor, and presently as the chief of the division for at least the last 10 years.

Los Angeles County has approximately 400 nursing homes, caring for approximately 40,000 patients. This represents approximately one-third of California's total nursing homes and patient population.

Our experience shows that nursing homes fall into three broad categories—first, as was stated this morning, those in superior care—and the problem with that is that there probably are anywhere from 2- to 3-year waiting lists to get into the superior care facilities, second, facilities that, although providing minimum level of acceptable care, are in need of some form of constant and repeated monitoring. Most of the facilities seem to fall into this category. And then, third, facilities that repeatedly violate regulations, jeopardizing the health and safety of patients. These comprise probably 10 percent, but they require a very disproportionate allocation of manpower and legal resources.

In 1976, Los Angeles County determined that there was a need to coordinate enforcement and develop a coordinated enforcement program to deal with nursing home problems. A special unit was created within the division to monitor and provide enforcement expertise for specific division activities that were separate and apart from routine inspection functions.

The activities of the unit were and continue to be focused on evidence gathering, prosecution, and liaison with enforcement agencies and licensing boards.

It was clear to us that an investigation of rape, assault, or theft within health facilities required the same expertise on the same level as if the crimes occurred at some other location.

As a matter of county policy and actual practice, the health facilities division works closely and shares information on a routine basis with the chief medical examiner-coroner, the public guardian, and the office of the district attorney-nursing home abuse section. This allows for close review and monitoring of cases and enhances our coordinated efforts. It enhances the effort to prosecute individuals for specific criminal acts as well as owners and operators of nursing homes who willfully and repeatedly offer substandard care.

Although the overall quality of care at nursing homes has improved over the years, due largely, I think, to an increase in public awareness and concern, the highly vulnerable patient population continues to be subjected to a variety of outrageous sexual, physical, and financial abuses.

Some of the cases we have investigated and/or prosecuted with the assistance of the Los Angeles County District Attorney's Office include: A nurse's aide who forced an 82-year-old female patient into an act of oral copulation; a nurse's aide who was caught in the act of raping a 34-year-old female brain-impaired nursing home patient; a licensed vocational nurse who had intercourse with a 41-year-old female nursing home patient—our investigation showed that this very same nurse had been previously involved in aberrant sexual advances to another elderly comatose patient; the case of a 35-year-old brain-impaired female nursing home patient who was

discovered to be pregnant—the patient was bedridden and oblivious to her surroundings; a nurse's aide who allegedly abused a 74-year-old male patient to such an extent that he caused a massive subdural hematoma resulting in the patient's death. The nursing home denied any liability, claiming that the death was caused by natural causes. A coroner's inquest jury voted to change the death certificate from "accidental" to "death at the hands of another."

Cases of financial abuse, in our experience, have diminished in the past few years. However, the following recent case illustrates the need for continued surveillance.

A nursing home ordered a $692 television set for a patient without knowledge or specific authorization of that patient. The money for the set was obtained from the patient's personal trust account. Upon delivery, the television was placed in the facility closet and obviously soon disappeared. Aside from the blatant dishonesty involved, what makes this case tragic is that the patient was totally blind.

Patients' private funds held in trust by a nursing home are by law to be delivered to designated relatives upon death of patients, but oftentimes the families are unaware that the money is held in trust. And if the family fails to make an affirmative demand, the funds are siphoned off by the nursing homes.

A continuing challenge regarding the inspection of nursing homes is the so-called inspection window of predictability. Facilities generally can predict when they are due for an inspection, and they can undertake measures to assure that the facility is at its highest level of compliance. Consequently, the inspection findings may not be representative of the actual conditions.

I would note that we are now surveying all work shifts in Los Angeles County.

Recently, during the course of a routine inspection, our records disclosed information about a 76-year-old patient with bedsores. The records were really unremarkable, and the facility was apparently providing appropriate care, at least according to the records. However, our inspectors had previously obtained earlier photocopies of the record, and a comparison of the two disclosed extensive falsification of the record.[15]

Other violations included inadequate number of staff to adequately supervise and meet the needs of the patients.

Facilities know when their Medicare and Medicaid contracts expire, and that is a key point. They also know that the facility must be inspected prior to the issuance of a new provider agreement, which is approximately 30 days. So, we strongly recommend that greater emphasis be placed on truly unannounced and random inspections.

You will view a videotape taken at our request by Mr. Leland Harris of the Los Angeles County District Attorney's Office, while on an unannounced visit to a facility. Although the conditions depicted in the tape may not be typical of all nursing homes, they are reflective of conditions that are unfortunately all too common.

[Videotape shown.]

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[15] "Please see volume I, appendix 3, page 625."

Chairman HEINZ. Pretty tough stuff. And that is, you say, not uncommon?

Mr. LOPEZ. Well, one of our problems is the distance between reviewers and courts and people who terminate contracts on any level, State or Federal Governments, not really accepting what surveyor-inspectors say about conditions. And this effort was the advanced effort of our trying to get into videotaping—modern, high-technology evidence gathering—so that we will be able to demonstrate to either criminal courts or administrative hearings and others who really do not hear and feel and see what is going on.

[The prepared statement of Mr. Lopez follows:]

TESTIMONY BY RALPH LOPEZ

CHIEF, HEALTH FACILITIES DIVISION

LOS ANGELES COUNTY

DEPARTMENT OF HEALTH SERVICES

BEFORE

UNITED STATES SENATE

SPECIAL COMMITTEE ON AGING

JOHN HEINZ, CHAIRMAN

MAY 21, 1986

GOOD MORNING.

I AM RALPH LOPEZ, CHIEF OF HEALTH FACILITIES DIVISION FOR THE LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES.

HEALTH FACILITIES DIVISION IS RESPONSIBLE FOR THE INSPECTIONS OF HEALTH FACILITIES AND VARIOUS ANCILLARY SERVICES FOR STATE LICENSURE. AS A REPRESENTATIVE OF THE STATE AGENCY, WE ALSO INSPECT PROVIDERS FOR COMPLIANCE WITH MEDICARE AND MEDICAID REGULATIONS AND MAKE APPROPRIATE RECOMMENDATIONS REGARDING CERTIFICATION STATUS TO THE BUREAU OF HEALTH STANDARDS AND QUALITY, HEALTH CARE FINANCE ADMINISTRATION, HEALTH AND HUMAN SERVICES.

I HAVE BEEN INVOLVED IN THESE PROGRAMS FOR THE LAST 20 YEARS. FIRST AS A SURVEYOR SINCE THE INCEPTION OF MEDICARE, THEN AS A DISTRICT SUPERVISOR AND PRESENTLY AS CHIEF OF THE DIVISION.

LOS ANGELES COUNTY HAS 389 NURSING HOMES CARING FOR APPROXIMATELY 40,000 PATIENTS. THIS REPRESENTS APPROXIMATELY ONE-THIRD OF CALIFORNIA'S TOTAL NURSING HOMES AND PATIENT POPULATION.

OUR EXPERIENCE SHOWS THAT NURSING HOMES FALL INTO 3 BROAD CATEGORIES:

1. FACILITIES THAT EXCEED MINIMUM STANDARDS AND PROVIDE ABOVE AVERAGE CARE. WE ESTIMATE THAT APPROXIMATELY 20% OF OUR FACILITIES ARE IN THIS CATEGORY

2. FACILITIES THAT ALTHOUGH PROVIDING MINIMUM LEVEL OF ACCEPTABLE CARE, ARE IN NEED OF SOME FORM OF CONSTANT AND REPEATED MONITORING. MOST OF THE FACILITIES WITHIN

OUR PURVIEW FALL WITHIN THIS GENERAL CATEGORY.

3. FACILITIES THAT REPEATEDLY VIOLATE REGULATIONS JEOPARDIZING THE HEALTH AND SAFETY OF PATIENTS. SAID FACILITIES ALTHOUGH COMPRISING OF ONLY A MINORITY OF THE TOTAL NUMBER OF FACILITIES REQUIRE A DISPROPORTIONATE ALLOCATION OF MANPOWER AND LEGAL RESOURCES TO MONITOR. WE ESTIMATE THAT APPROXIMATELY 10% OF THE FACILITIES FALL INTO THIS CATEGORY.

IN 1976, LOS ANGELES COUNTY DETERMINED THAT THERE WAS A NEED FOR A COORDINATED ENFORCEMENT PROGRAM TO DEAL WITH NURSING HOME PROBLEMS. A SPECIAL UNIT WAS CREATED WITHIN THE DIVISION TO MONITOR AND PROVIDE ENFORCEMENT EXPERTISE FOR SPECIFIC DIVISION ACTIVITIES THAT WERE SEPARATE AND APART FROM THE ROUTINE INSPECTION FUNCTIONS. THE ACTIVITIES OF THE UNIT WERE AND CONTINUE TO BE FOCUSED ON EVIDENCE GATHERING, PROSECUTION AND LIAISON WITH ENFORCEMENT AGENCIES AND LICENSING BOARDS. IT WAS CLEAR TO US THAT AN INVESTIGATION OF RAPE, ASSAULT OR THEFT

WITHIN HEALTH SETTINGS REQUIRED EXPERTISE ON THE SAME LEVEL AS IF THE CRIMES OCCURRED AT SOME OTHER LOCATION.

AS A MATTER OF COUNTY POLICY AND ACTUAL PRACTICE, THE HEALTH FACILITIES DIVISION WORKS CLOSELY AND SHARES INFORMATION ON A ROUTINE BASIS WITH THE CHIEF MEDICAL EXAMINER-CORONER, THE PUBLIC GUARDIAN, AND THE OFFICE OF THE DISTRICT ATTORNEY-NURSING HOME ABUSE SECTION.THIS ALLOWS FOR CLOSE REVIEW AND MONITORING OF CASES AND ENHANCES THE COORDINATED EFFORTS TO PROSECUTE INDIVIDUALS FOR SPECIFIC CRIMINAL ACTS AS WELL AS OWNERS AND OPERATORS OF NURSING HOMES WHO WILLFULLY OR REPEATEDLY OFFER SUBSTANDARD CARE.

ALTHOUGH THE OVERALL QUALITY OF CARE IN NURSING HOMES HAS IMPROVED OVER THE YEARS-DUE LARGELY TO AN INCREASE IN PUBLIC AWARENESS AND CONCERN--THE HIGHLY VULNERABLE PATIENT POPULATION CONTINUES TO BE SUBJECTED TO A VARIETY OF OUTRAGEOUS SEXUAL, PHYSICAL AND FINANCIAL ABUSES.

SOME OF THE CASES WE HAVE INVESTIGATED AND OR PROSECUTED WITH THE ASSISTANT LOS ANGELES COUNTY DISTRICT ATTORNEY'S OFFICE INCLUDE:

A) A NURSES AIDE WHO FORCED AN 82-YEAR-OLD FEMALE PATIENT INTO AN ACT OF ORAL COPULATION.

B) A NURSES AIDE WHO WAS CAUGHT IN THE ACT OF RAPING A 34-YEAR-OLD FEMALE BRAIN-IMPAIRED NURSING HOME PATIENT.

C) A LICENSED VOCATIONAL NURSE WHO HAD INTERCOURSE WITH A 41-YEAR-OLD FEMALE NURSING HOME PATIENT. OUR INVESTIGATION SHOWED THAT THIS SAME NURSE WAS INVOLVED IN ABERRANT SEXUAL ADVANCES TO A 77-YEAR-OLD COMATOSE FEMALE PATIENT FIVE YEARS EARLIER.

D) THE CASE OF A 35-YEAR-OLD BRAIN IMPAIRED FEMALE NURSING HOME PATIENT WHO WAS DISCOVERED TO BE PREGNANT. THE PATIENT WAS BEDRIDDEN AND OBLIVIOUS TO HER SURROUNDINGS.

E) A NURSES AIDE WHO ALLEGEDLY ABUSED A 74-YEAR-OLD MALE PATIENT TO SUCH AN EXTENT THAT HE CAUSED A MASSIVE SUBDURAL HEMATOMA RESULTING IN THE PATIENT'S DEATH. THE NURSING HOME DENIED ANY LIABILITY CLAIMING THAT THE DEATH WAS CAUSED BY NATURAL CAUSES. A CORONER'S INQUEST JURY VOTED TO CHANGE THE DEATH CERTIFICATE FROM "ACCIDENTAL" TO "DEATH AT THE HANDS OF ANOTHER".

CASES OF FINANCIAL ABUSE IN OUR EXPERIENCE HAVE DIMINISHED IN THE PAST FEW YEARS. HOWEVER, THE FOLLOWING RECENT CASE ILLUSTRATES THE NEED FOR CONTINUED SURVEILLANCE. A NURSING HOME ORDERED A $692 TELEVISION SET FOR A PATIENT WITHOUT THE KNOWLEDGE OR SPECIFIC AUTHORIZATION OF THAT PATIENT. THE MONEY FOR THE SET WAS OBTAINED FROM THE PATIENT'S PERSONAL TRUST ACCOUNT. UPON DELIVERY, THE TELEVISION SET WAS PLACED IN A FACILITY CLOSET AND SOON DISAPPEARED. ASIDE FROM THE BLATANT DISHONESTY INVOLVED, WHAT MAKES THIS CASE TRAGIC IS THAT THE PATIENT WAS TOTALLY BLIND.

A CONTINUING CHALLENGE REGARDING THE INSPECTION OF NURSING HOMES IS THE SO-CALLED INSPECTION "WINDOW OF PREDICTABILITY". FACILITIES GENERALLY CAN PREDICT WHEN THEY ARE DUE FOR AN INSPECTION AND CAN UNDERTAKE MEASURES TO ASSURE THAT THE FACILITY IS AT AN OPTIMAL LEVEL OF COMPLIANCE. CONSEQUENTLY, THE INSPECTION FINDINGS MAY NOT BE REPRESENTATIVE OF THE ACTUAL CONDITIONS AT THE FACILITY. RECENTLY, DURING THE COURSE OF A ROUTINE VISIT OUR INSPECTORS NOTED INITIALLY THAT THE RECORDS OF A 76 YEAR OLD PATIENT WITH BEDSORES WAS UNREMARKABLE AND THE FACILITY WAS APPARENTLY PROVIDING APPROPRIATE CARE. HOWEVER, OUR INSPECTORS HAD PREVIOUSLY OBTAINED EARLIER PHOTOCOPIES OF THE RECORD AND A COMPARISON OF THE TWO DISCLOSED EXTENSIVE FALSIFICATION OF THE RECORD.

TRULY UNANNOUNCED AND RANDOM INSPECTIONS HAVE DEMONSTRATED EVIDENCE OF PATIENT NEGLECT AND POOR CARE. PATIENTS HAVE BEEN OBSERVED TO SIT OR LIE IN THEIR BODY WASTE FOR EXTENDED PERIODS OF

TIME. OTHER VIOLATIONS INCLUDED INADEQUATE NUMBER OF STAFF TO ADEQUATELY SUPERVISE AND MEET THE NEEDS OF THE PATIENTS.

FACILITIES KNOW WHEN THEIR MEDICARE AND/OR MEDICAID CONTRACTS EXPIRE AND THEY ALSO KNOW THAT THE FACILITY MUST BE INSPECTED PRIOR TO THE ISSUANCE OF A NEW PROVIDER AGREEMENT. WE STRONGLY RECOMMEND THAT GREATER EMPHASIS BE PLACED ON TRULY UNANNOUNCED AND RANDOM INSPECTIONS.

YOU WILL VIEW A VIDEO TAPE TAKEN AT OUR REQUEST BY MR. LELAND HARRIS OF THE LOS ANGELES COUNTY DISTRICT ATTORNEY'S OFFICE, NURSING HOME ABUSE SECTION, WHILE ON AN UNANNOUNCED VISIT TO A FACILITY. ALTHOUGH THE CONDITIONS DEPICTED IN THE TAPE MAY NOT BE TYPICAL OF ALL NURSING HOMES, THEY ARE REFLECTIVE OF CONDITIONS THAT ARE UNFORTUNATELY ALL TOO COMMON.

Chairman HEINZ. Let me turn to Ms. Casper. Before you begin your testimony, Ms. Casper, let me ask you, you are a former nursing home administrator, I understand; is that right?

Ms. CASPER. Yes.

Chairman HEINZ. Could you give us your impression of what we just saw?

Ms. CASPER. Yes. I not only am a nursing home administrator, I am also a registered nurse. I have spent the last 15 years of my career dealing with a wide variety of long-term care issues, both from the provider's side as a director of nursing as well as the regulator's side as an inspector, and a researcher in long-term care. I believe the film stands on its own merit. It has a very deep and profound effect on me. I guess it goes without saying that now is not the time to perhaps rest on our laurels; if we have made progress there is a long way to go.

Chairman HEINZ. Do you want to proceed with your statement?

STATEMENT OF SANDRA K. CASPER, PRESIDENT, REHABILITATION CARE CONSULTANTS, MADISON, WI

Ms. CASPER. I would be happy to, thank you.

My name is Sandra Casper, I am a registered nurse and a licensed nursing home administrator. I am president of Rehabilitation Care Consultants, which is a health care consulting firm located in Madison, WI.

We have been very involved with a wide variety of long-term care issues since 1980. RCC is in a very unique position in that we have evaluated four of the six State survey demonstrations that HCFA has funded. In addition, we evaluated the new PACS process that you heard referenced earlier today in the 47 nondemonstration States across the country this past year.

Thus, I feel that we are in a unique position, and we have some semblance of knowledge, I hope, about what works and what does not work in a regulatory process. So, for whatever value I can bring to the committee in its very important task today, I am happy to be here.

Much time, attention, and fiscal resource has been given to the issue of the provision of quality care to residents in our Nation's nursing homes—and rightly so. As demographics clearly tell us, our population is aging, and the quality of long-term care is a basic expectation that indeed deserves national attention.

The question then becomes, where do we find the long-term care delivery system today, and what is the result of the resource allocation that we have already given to this very important issue to date?

RCC and its staff have now traveled to over 30 States, evaluating long-term care issues on a wide variety of fronts, both from the provider and the regulatory perspective. These experiences have led us to believe that more can, and, indeed, should be done to ensure that all residents of long-term care facilities receive the quality and type of care to which they are entitled, and indeed, for which we all pay.

In the State where I am from, the State of Wisconsin, we have made a great deal of progress on this front. However, this progress is not consistently evident on a national level.

While there are obviously some very excellent long-term care facilities across the Nation that truly care about the residents for whom they are responsible, problem facilities still exist. Thus, I believe it is critical that we continue to press ahead with identification, and, more importantly, correction, of the causes of these chronically substandard facilities.

So what are these problems and what can we do to fix them?

Perhaps the best way for me to attempt to briefly answer some of these questions is to develop several very real case scenarios for you and attempt to address the question of why they occurred. There is clearly no need for me to draw from hypothetical or theoretical cases. My staff and I have plenty of real life case situations from which to draw.

For example, in one State, a facility was accepting residents for admission that they simply were unable to care for. One resident who was receiving her nutrition through a nasogastric tube, continued to lose weight, developed bedsores all over her body, including her ears, and finally weakened to the point of hospital admission and death.

It was found upon review of her medical records that her physician's order for the number of calories she was to receive each day was so low that it was deemed to be below the starvation rate by the nutritionist who evaluated the record.

In another facility, a resident was left unattended in a bathtub by an untrained nursing assistant, and the resident drowned.

How and why do these situations occur? Simply, the nursing staff at these facilities did not know enough about the residents for whom they were responsible to care for them in an appropriate and professionally acceptable fashion.

In another State, while RCC was onsite evaluating the application of a State licensure and Federal certification survey process, RCC observed that the State inspector found no deficiencies to be present in the facility, that we were in.

However, it was the opinion of the RCC staff, based on such examples as a newly admitted stroke patient who was not receiving physical therapy and thus was already developing contractures of both his upper and lower extremities after less than a week of residency in this facility, that this decision was in error. The situation was brought to the attention of the State agency by RCC, as we felt a moral and ethical responsibility to do so, even though it clearly was outside our research design.

The State responded by sending in another inspector who agreed with RCC and overturned the decision of the initial inspector.

To take this one step further the Federal "look behind" option was implemented in this facility as well. The Federal inspectors obviously also agreed with RCC since they declared a state of jeopardy to exist in this facility. However, no Federal followup occurred to be sure that correction of these situations took place until over 60 days later.

How could these situations occur?

Survey staff were simply not able to detect potentially life-threatening resident care issues. This, coupled with very lengthy Federal intervention, led to the noncorrection and noncompliance of very severe resident-specific problems that, in our opinion, threatened the life and safety of the residents in this particular facility.

My last example is related to a facility where resident needs consistently are not met. To me, this is an example of a "chronically substandard" nursing home that continues to operate because there are no legal remedies available to the survey and certification agencies.

Residents with huge, open, infected bedsores are in the same room, and cross-contamination of the infections is occurring because the staff does not employ proper isolation techniques and are not trained to implement these highly skilled procedures. Untrained nursing assistants were observed, moving from patient to patient, changing their dressings, not washing their hands between patients, using one patient's medication for another, and generally functioning in a totally unacceptable fashion.

In addition, the water temperature was so low in this facility that proper aseptic technique was indeed even physically impossible to attain.

Again we ask the question: How does this happen?

The Federal Government has delegated much of its responsibility for enforcement of these issues to the State agencies. However, the State agencies tell us that these cases persist because they have no appropriate legal remedy available to them if they attempt to litigate these types of very resident-specific issues.

In essence, I have laid out problems in four basic areas that must be addressed before we feel we have at least begun to do our job in assuring quality of care and, just as importantly, quality of life to the residents in our Nation's long-term care facilities.

Point No. 1: Staff in nursing homes must be competent and able to care for the residents for whom they are responsible. This requires adequate reimbursement to facilities to attract and hire such staff, as well as an upgrading of the image of the staff that work in our Nation's long-term care facilities.

Point No. 2: State and Federal inspectors must be highly skilled and knowledgeable in the state of the art of long-term care. This requires much more stringent hiring, training and supervision of these very important key personnel.

Point No. 3: The Federal system of monitoring State inspection performance is not consistent between Federal regions and does not always result in strong Federal sanctions against problem facilities. This requires a role definition and consistent application of this definition at the Federal level.

My fourth and final point: Enforcement of regulation in a consistent and fair fashion is a very effective way of correcting problems in nursing homes. States with strong enforcement sanctions, my home State of Wisconsin being one, will surely attest to this fact.

However, this requires laws that will stand up in court and put the poor providers out of business, as well as laws that are not arbitrary and capricious and tie up many hours of both provider and

regulator time in court on nonsubstantive, trivial, paper compliance kinds of issues.

This kind of litigation carries a huge cost to all concerned, but most importantly to the residents of our Nation's long-term care facilities.

Thank you very much for the opportunity to appear before you this morning.

[The prepared statement of Ms. Casper follows:]

Testimony of

SANDRA K. CASPER

before the

U.S. SENATE SPECIAL COMMITTEE ON AGING

May 21, 1986

Much time, attention, and fiscal resource has been given to the issue of care provision to residents of our nation's nursing homes -- and rightly so. As demographics clearly tell us, our population is aging and the provision of quality long term care is a basic expectation that indeed deserves national attention.

The question thus becomes, then, where do we find the long term care delivery system today? What is the result of the resource allocation that has been given this issue to date?

Rehabilitation Care Consultants, Inc. (RCC) and its staff have traveled to 30 states in a variety of roles -- evaluating both providers and regulators. These experiences have led us to believe that more can and should be done to ensure that all residents of long term care facilities receive the quality and type of care to which they are entitled.

In my home state, we have made a great deal of progress toward improving quality of care by strengthening enforcement of standards. Unfortunately, this progress has not been paralleled in the rest of the country. We must press ahead with identification and correction of several problems that still exist.

So what are these problems and what can we do to "fix" them? Perhaps the best way to answer these questions is to develop several very real case scenarios for you and attempt to address the question of why they occurred. There is no need to deal with hypothetical or theoretical cases when we have plenty of real life cases from which to draw.

For example, in one State a facility was accepting residents for admission that they were simply unable to care for. One resident, who was receiving her nutrition through a naso-gastric tube continued to lose weight, develop bedsores all over her body, including her ears, and finally weakened to the point of hospital admission and death. It was found that her physician's order for the number of calories she was to receive each day was so low that it was at the starvation rate. In another facility, a resident was left unattended in a bath tub by an untrained nursing assistant and the resident drowned. How and why did these situations occur? The nursing staff at these facilities simply did not know enough about

the residents for whom they were responsible to care for them in an appropriate and professionally acceptable fashion.

In another State, while evaluating the application of a state licensure and Federal certification survey, RCC observed that the surveyor found no deficiencies to be present in this facility. But it was the opinion of the RCC staff, based upon such problems as a newly admitted stroke patient who was not receiving physical therapy and thus was already developing contractures of his upper and lower extremities, that this decision was in error. The situation was brought to the attention of the State agency by RCC, as we felt a moral and ethical responsibility to do so. The State responded by sending in another surveyor who agreed with RCC and over turned the decision of the initial surveyor. To take this one step further, the Federal look behind option was implemented in this facility as well. The federal surveyors apparently also agreed with RCC since they decided a state of jeopardy existed in this facility. However, no Federal follow up occurred to be sure correction of these situations took place until <u>over 60 days</u> later.

How could these situations occur? Survey staff was simply not able to detect potentially life threatening resident care issues. This, coupled with lethargic Federal intervention, led to the noncorrection and noncompliance of very severe problems that threatened the life and safety of residents.

My last example is related to a facility where resident needs consistently are not met. This to me is an example of a "chronically substandard" nursing home. This facility continues to operate because there are no legal remedies available to the survey and certification agency. At this facility, residents with huge, open, infected bedsores are in the same room and cross contamination of the infections is occurring because staff does not employ proper isolation techniques and are not trained to implement these highly skilled techniques. Untrained nursing assistants were observed moving from patient to patient changing their dressings, not washing their hands between patients, using one patient's medications for another, and generally functioning in a totally unacceptable fashion. In addition, the water temperature was so low in this facility that proper aseptic technique was indeed physically impossible to attain.

How does this happen? The Federal government has abrogated it's responsibility for enforcement and has left this job to theStates. However, state agencies say these cases persist because they have no appropriate legal remedy available to them if they attempt to litigate these types of problems.

In essence, I have laid out problems in four basic areas that must be addressed before we can feel we have done our job in assuring quality of care and quality of life to the residents of our nation's long term care facilities.

1. Staff in nursing homes must be competent and able to care for the residents for whom they are responsible. This requires adequate reimbursement to facilities to attract and hire such staff and an upgrading of the image of the staff that work in our nation's nursing homes.

2. State and Federal nursing home inspectors must be highly skilled and knowledgeable in the state-of-the-art of long term care. This requires more stringent hiring, training, and supervision of these very important personnel.

3. The federal system of monitoring state inspection performance is not consistent between regions and does not always result in strong Federal sanctions against problem facilities. This requires a job definition and consistent application of this definition at the national/Federal level.

4. Enforcement of regulation in a consistent and fair fashion is a very effective way of correcting problems in nursing homes. States with strong enforcement laws will surely attest to this fact. This requires laws that will stand up in court and put the poor providers out of business, as well as laws that are not arbitrary and capricious and tie up many hours of both provider and regulator time in court on nonsubstantive issues, at a huge cost to all concerned, most importantly, the residents of our nation's long term care facilities.

Chairman HEINZ. Ms. Casper, I think Senator Cohen has a comment.

Senator COHEN. Just one quick question. You gave an example of one patient who died, I take it, as a result of malnutrition.

Ms. CASPER. Yes.

Senator COHEN. Was any action ever taken by the facility or by the relatives of that patient against the doctor?

Ms. CASPER. In fact, most of the cases that I referenced are under litigation at this time. Yes, action is currently underway on all of the instances.

Senator COHEN. But how did the action come about? Did the facility itself take action against the physician, or was it forced by the State or by an administrator?

Ms. CASPER. In the particular one you referenced, where the woman was receiving a 600-calorie-a-day diet, action was brought by the district attorney for the State against the facility.

Senator COHEN. But the facility took no action itself?

Ms. CASPER. No, it did not. In fact, they litigated.

Chairman HEINZ. Thank you, Senator Cohen.

Mr. Thompson.

STATEMENT OF CONRAD THOMPSON, DIRECTOR, WASHINGTON BUREAU OF NURSING HOME AFFAIRS, OLYMPIA, WA

Mr. THOMPSON. Mr. Chairman, committee members, my name is Conrad Thompson. I am the director of the bureau of nursing home affairs for the State of Washington. The bureau is responsible for licensure and certification of nursing homes. In addition, the bureau is responsible for the Federal utilization, control, and inspection of care requirements and the setting of nursing home payment rates for Medicaid recipients.

The State has about 300 nursing homes with a total of 27,000 beds, of which 60 percent are occupied by Medicaid recipients.

I am going to briefly testify on the following topics: The new Federal nursing home inspection process, the need for adequate funds to inspect nursing homes, the need for key enforcement sanctions, the new Federal termination procedures, the continuing problem of Medicaid discrimination against Medicaid recipients, and national training standards for nursing assistants.

First, in late 1984, the U.S. Court of Appeals in a landmark case found for the plaintiffs, *Smith and the State of Colorado* v. *Heckler*, then Secretary for the Department of Health and Human Services. The court determined that the present Federal survey process does not judge quality of resident care.[16]

In response partly to the court's ruling, we have the new developed Federal nursing home inspection process, formerly called PACS. I understand the implementation date has now been moved up to July 1, 1986. The new process focuses on patients, rather than the facility's capacity and compliance with paper requirements. In this respect it is a significant step forward. However, the process has fundamental flaws. To make it a valid and reliable instrument, the following changes are needed: One, inclusion of a

[16] "Please see appendix 4, page 818, for documents pertaining to *Smith* v. *Bowen*."

standardized patient assessment process, which gets at the heart of what Sandra was talking about; two, development of a statistically valid sampling methodology; three, proper training for surveyors; and four, stronger focus on resident rights.

There is a critical need for adequate funds to inspect nursing homes. I would comment both with respect to Senator Pryor's and Senator Pressler's questions that there is no surprise element on survey. This is due to insufficient resources. As has been pointed out here already, the survey date can be figured out very easily by providers.

There should not only be evening surveys; there should be a Federal requirement for a percentage of evening and/or weekend surveys.

The integrity of the nursing home inspection process is dependent upon adequate funding and the surprise element. Surveyors should not be showing up at the facility when the facility is expecting them.

I am very troubled by current proposals to reduce Federal funds for nursing home inspections. To reduce budgets when a new inspection process is being implemented which requires additional resources, poses the gravest consequences for this Nation's ability to monitor the quality of health care in our nursing homes across the country. I would point out that presently less than 1 percent of the Federal Medicaid budget goes to fund nursing home inspections. The 1986 Federal Medicaid budget for the entire Nation is only $44 million.

I strongly favor the National Academy of Sciences IOM Report that recommends 100 percent Federal funding for Federal nursing home inspections.[17] I would add respectfully that a dollar is just as important to you at the Federal Government level as it is at the State level. I understand that a $100 million item is not even itemized in the Federal budget. Can you imagine how much we could strengthen this Nation's nursing home system with $95 million? It would be incredible.

We need some key enforcement sanctions. Federal Medicaid Program requirements should include an effective array of enforcement sanctions. It is not in the best interest of nursing home residents that the only Federal sanction is cancellation of the Medicaid contract. I have serious reservations about withholding the payments. A contract cancellation forces the relocation of Medicaid residents, and it punishes the wrong party.

Sanctions will assist the State and Federal Governments in assuring quality of care for nursing home residents. Three sanctions are needed:

First, a ban on admissions. When resident care is substandard, a ban on admissions is the most valuable enforcement tool that we can have. New admissions, as Sandra here could tell you, require a substantial amount of work. The ban protects the health and safety of residents by forcing the facility to target resources toward correction of deficiencies. Further, a ban on admissions creates a fi-

[17] See p. 139 for the position statement of the AHFLCD on the IOM report.

nancial incentive and puts public pressure on the nursing home to achieve and maintain compliance with health and safety standards.

Second, civil fines. They are an enforcement option badly needed by program administrators. They have proven to be a valuable enforcement tool in numerous States. I hope someone will ask me about substandard homes, because I have a few suggestions to make.

Third, receivership. Receivership is a temporary action to protect the health and safety of residents when a nursing home cannot meet the care needs of its residents. Receivership permits the State to act as a manager of the home and as a trustee until the quality of care is restored.

What about the new Federal termination procedures? I want to commend HHS for their work to improve Federal termination procedures. However, the procedures do not provide appropriate responses for receivership or ownership changes. The problem is that even if the nursing home provider is the source of the trouble, and a new, credible owner takes over, the new procedures still force the relocation of all Medicaid recipients. Isn't that a little like throwing the baby out with the bathwater? I believe it is.

HHS further informs us that the new procedures only apply to Medicare. Yet they recommended them for use by the States in administering the Medicaid Program. This ambiguity has created problems for the States. No Federal regulations have been promulgated to apply these termination procedures to Medicaid. The failure of HHS to deal specifically with Medicaid certainly seems inconsistent with the court's ruling in the *Smith* case. Moreover, they are not consistent with Medicaid requirements. For example, they do not provide for a timely—and I emphasize timely—informal conference with the nursing home provider prior to termination, which is currently a requirement under the Code of Federal Regulations.

With respect to the continuing problem of Medicaid discrimination against Medicaid recipients, I applaud the work of Senator Heinz and this committee to eliminate discrimination against Medicaid recipients. Your work is deeply appreciated. Clearly, our most frail and defenseless elderly citizens should not have to fight Medicaid discrimination in addition to the aging process.

Washington State has already recognized this by enacting legislation prohibiting discrimination against Medicaid recipients. The lack of antidiscrimination enforcement currently undermines the basic entitlement of Medicaid recipients to receive nursing home care. My written submitted testimony lists examples of discrimination which should be unlawful for any nursing home with a Medicaid contract.

My last point—and I want to stress it, because to me it is critically important—is nurse aide training. The importance of nurse aide training cannot be overstated.

Nursing assistants, often referred to as nurse aides, deliver more than 80 percent of resident care in nursing homes. The Federal Government should mandate national training standards for nursing assistants. It is not that expensive.

In closing, I want to thank you again for this opportunity to contribute to the improvement of quality of life and quality of care for nursing home residents.

[The prepared statement of Mr. Thompson follows:]

THE UNITED STATES SENATE

SPECIAL COMMITTEE ON AGING

SENATOR JOHN HEINZ, CHAIRMAN

TESTIMONY BY CONRAD THOMPSON, DIRECTOR

BUREAU OF NURSING HOME AFFAIRS

WASHINGTON STATE

MAY 21, 1986

MR. CHAIRMAN AND COMMITTEE MEMBERS:

THANK YOU FOR THIS OPPORTUNITY TO TESTIFY WITH RESPECT TO NURSING HOME RESIDENTS. MY NAME IS CONRAD THOMPSON. I SERVE AS DIRECTOR OF THE BUREAU OF NURSING HOME AFFAIRS FOR THE STATE OF WASHINGTON AND HAVE FOR THE PAST SEVEN YEARS. THE BUREAU IS RESPONSIBLE FOR STATE LICENSURE AND FEDERAL CERTIFICATION OF NURSING HOMES. IN ADDITION, THE BUREAU IS RESPONSIBLE FOR FEDERAL UTILIZATION REVIEW AND INSPECTION OF CARE REQUIREMENTS AND ESTABLISHES MEDICAID PAYMENT RATES FOR NURSING HOME CARE. THE STATE HAS ABOUT THREE HUNDRED NURSING HOMES, WITH A TOTAL OF 27,000 BEDS. SIXTY PERCENT OF THESE BEDS ARE OCCUPIED BY MEDICAID RECIPIENTS.

I WILL DISCUSS THE FOLLOWING TOPICS:

- NEW FEDERAL NURSING HOME INSPECTION PROCESS
- NEED FOR ADEQUATE FUNDS TO INSPECT NURSING HOMES
- NEED FOR THREE KEY ENFORCEMENT SANCTIONS
- NEW FEDERAL NURSING HOME TERMINATION PROCEDURES
- CONTINUING PROBLEM OF DISCRIMINATION AGAINST MEDICAID RECIPIENTS
- NATIONAL TRAINING STANDARDS FOR NURSING ASSISTANTS
- NATIONAL ACADEMY OF SCIENCES' REPORT ON NURSING HOMES
- EXCEEDINGLY HARSH AUDIT PENALTIES

NEW FEDERAL NURSING HOME INSPECTION PROCESS

IN 1984, THE UNITED STATES COURT OF APPEALS, IN A LANDMARK CASE, FOUND FOR THE PLAINTIFFS, SMITH AND THE STATE OF COLORADO, VS. HECKLER, THEN SECRETARY FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS). THE COURT RULED THAT THE FEDERAL NURSING HOME ENFORCEMENT SYSTEM MUST ENSURE THAT MEDICAID RECIPIENTS ARE RECEIVING QUALITY CARE AND THAT THE SECRETARY OF HHS HAS A DUTY WITH RESPECT TO QUALITY CARE.

THE COURT DETERMINED THAT THE PRESENT FEDERAL SURVEY PROCESS DOES NOT JUDGE QUALITY OF RESIDENT CARE. THE COURT'S RULING AND JOHN HOLLAND, COUNSEL FOR THE PLAINTIFFS, CREATED A TREMENDOUS OPPORTUNITY TO IMPROVE AND ASSURE QUALITY CARE FOR NURSING HOME RESIDENTS.

IN RESPONSE TO THE COURT'S RULING, HHS DEVELOPED THE NEW FEDERAL NURSING HOME INSPECTION PROCESS, FORMERLY CALLED PACS. I UNDERSTAND THE IMPLEMENTATION DATE HAS NOW BEEN MOVED UP TO JULY 1, 1986. THE NEW PROCESS FOCUSES ON THE QUALITY OF CARE PROVIDED RATHER THAN THE FACILITY'S COMPLIANCE WITH PAPER REQUIREMENTS. IN THIS RESPECT, IT IS A SIGNIFICANT STEP FORWARD. HOWEVER, THE NEW PROCESS HAS FUNDAMENTAL FLAWS. TO MAKE IT A VALID AND RELIABLE PROCESS, THE FOLLOWING CHANGES ARE NEEDED:

- INCLUSION OF A STANDARDIZED PATIENT ASSESSMENT PROCESS,

- DEVELOPMENT OF A STATISTICALLY VALID SAMPLING METHODOLOGY,

- PROPER TRAINING FOR SURVEYORS, AND

- STRONGER FOCUS ON RESIDENT RIGHTS, THE PHYSICAL PLANT ENVIRONMENT AND ADMINISTRATIVE RESPONSIBILITY.

NEED FOR ADEQUATE FUNDS TO INSPECT NURSING HOMES

THE INTEGRITY OF THE NURSING HOME INSPECTION PROCESS IS DEPENDENT UPON ADEQUATE FUNDING AND THE SURPRISE ELEMENT. SURVEYORS SHOULD NOT BE SHOWING UP WHEN THE FACILITY IS EXPECTING THEM. I AM TROUBLED BY CURRENT PROPOSALS TO REDUCE FEDERAL FUNDS FOR NURSING HOME INSPECTIONS. TO REDUCE BUDGETS WHEN A NEW INSPECTION PROCESS IS BEING IMPLEMENTED, WHICH REQUIRES ADDITIONAL RESOURCES, POSES THE GRAVEST CONSEQUENCES FOR THE NATION'S ABILITY TO MONITOR THE QUALITY OF HEALTH CARE.

PRESENTLY, LESS THAN ONE PERCENT OF THE FEDERAL MEDICAID BUDGET GOES TO FUND NURSING HOME INSPECTIONS. THE 1986 FEDERAL MEDICAID BUDGET FOR THE ENTIRE NATION IS ONLY FORTY-FOUR MILLION DOLLARS. I AM IN FAVOR OF THE RECOMMENDATION BY THE NATIONAL ACADEMY OF SCIENCES, WHICH CALLS FOR REINSTITUTING ONE HUNDRED PERCENT FEDERAL FUNDING FOR NURSING HOME CERTIFICATION INSPECTIONS.

NEED FOR THREE KEY ENFORCEMENT SANCTIONS

FEDERAL MEDICAID PROGRAM REQUIREMENTS SHOULD INCLUDE AN EFFECTIVE ARRAY OF ENFORCEMENT SANCTIONS. IT IS NOT IN THE BEST INTERESTS OF NURSING HOME RESIDENTS THAT THE ONLY FEDERAL SANCTION IS CANCELLATION OF THE MEDICAID CONTRACT. A CONTRACT CANCELLATION FORCES THE RELOCATION OF MEDICAID RESIDENTS, PUNISHING THE WRONG PARTY. SANCTIONS WILL ASSIST THE STATE AND FEDERAL GOVERNMENT IN ASSURING QUALITY CARE FOR NURSING HOME RESIDENTS. SANCTIONS NEEDED ARE:

1. A BAN ON ADMISSIONS. WHEN RESIDENT CARE IS SUBSTANDARD, A BAN ON ADMISSIONS IS A VALUABLE ENFORCEMENT TOOL. NEW ADMISSIONS REQUIRE A SUBSTANTIAL AMOUNT OF WORK. THE BAN PROTECTS THE HEALTH AND SAFETY OF RESIDENTS BY FORCING THE FACILITY TO TARGET RESOURCES TOWARD CORRECTION OF DEFICIENCIES. FURTHER, A BAN ON ADMISSIONS CREATES A FINANCIAL INCENTIVE AND PUTS PUBLIC PRESSURE ON THE NURSING HOME TO ACHIEVE AND MAINTAIN COMPLIANCE WITH HEALTH AND SAFETY STANDARDS.

2. CIVIL FINES. CIVIL FINES ARE AN IMPORTANT ENFORCEMENT OPTION TO PROGRAM ADMINISTRATORS. THEY HAVE PROVEN TO BE A VALUABLE ENFORCEMENT TOOL IN NUMEROUS STATES.

3. RECEIVERSHIP. RECEIVERSHIP IS A TEMPORARY ACTION TO PROTECT THE HEALTH AND SAFETY OF RESIDENTS. WHEN A NURSING HOME CANNOT MEET THE CARE NEEDS OF ITS RESIDENTS, RECEIVERSHIP PERMITS THE STATE TO ACT AS A MANAGER OF THE HOME AND AS A TRUSTEE ON BEHALF OF RESIDENTS UNTIL QUALITY OF CARE IS RESTORED.

NEW FEDERAL NURSING HOME TERMINATION PROCEDURES

HHS SHOULD BE COMMENDED FOR ITS WORK TO IMPROVE FEDERAL TERMINATION PROCEDURES. HOWEVER, THE PROCEDURES DO NOT PROVIDE FOR APPROPRIATE RESPONSES TO RECEIVERSHIP ACTIONS OR OWNERSHIP CHANGES. THE PROBLEM IS THAT, EVEN IF THE NURSING HOME PROVIDER IS THE SOURCE OF THE TROUBLE AND A NEW CREDIBLE OWNER TAKES OVER, THE NEW PROCEDURES STILL FORCE THE RELOCATION OF ALL MEDICAID RECIPIENTS. ISN'T THIS THROWING THE BABY OUT WITH THE BATH WATER?

HHS INFORMS US THE NEW PROCEDURES ONLY APPLY TO MEDICARE. YET, THEY "RECOMMENDED" THE STATES USE THEM IN ADMINISTERING THE MEDICAID PROGRAM. THIS AMBIGUITY CREATES PROBLEMS FOR THE STATES. NO FEDERAL REGULATIONS HAVE BEEN PROMULGATED TO APPLY THESE TERMINATION PROCEDURES TO MEDICAID. THE FAILURE OF HHS TO DEAL SPECIFICALLY WITH MEDICAID SEEMS INCONSISTENT WITH THE COURT'S RULING IN THE SMITH CASE. MOREOVER, THEY ARE NOT CON-

SISTENT WITH MEDICAID REQUIREMENTS. FOR EXAMPLE, THEY DO NOT PROVIDE FOR AN INFORMAL CONFERENCE WITH THE NURSING HOME PROVIDER PRIOR TO TERMINATION, WHICH IS A CLEAR REQUIREMENT UNDER THE CODE OF FEDERAL REGULATIONS.

CONTINUING PROBLEM OF DISCRIMINATION AGAINST MEDICAID RECIPIENTS

I APPLAUD THE WORK OF SENATOR HEINZ AND THIS COMMITTEE TO ELIMINATE DISCRIMINATION AGAINST MEDICAID RECIPIENTS. YOUR WORK IS DEEPLY APPRECIATED. CLEARLY, OUR MOST FRAIL AND DEFENSELESS CITIZENS SHOULD NOT HAVE TO FIGHT MEDICAID DISCRIMINATION, IN ADDITION TO THE AGING PROCESS. THE STATE OF WASHINGTON HAS ALREADY RECOGNIZED THIS BY ENACTING LEGISLATION PROHIBITING DISCRIMINATION AGAINST MEDICAID RECIPIENTS. IT INCLUDES PROVISIONS FOR CIVIL FINES AND THE APPLICATION OF STATE CONSUMER PROTECTION LAWS.

THE LACK OF FEDERAL ANTI-DISCRIMINATION RULES UNDERMINES THE BASIC ENTITLEMENT OF MEDICAID RECIPIENTS TO RECEIVE NECESSARY NURSING HOME CARE. IT SHOULD BE UNLAWFUL FOR ANY NURSING HOME WITH A MEDICAID CONTRACT TO:

A) REQUIRE, AS A CONDITION OF ADMISSION, ASSURANCE FROM THE RESIDENT OR ANY OTHER PERSON THAT THE RESIDENT IS NOT ELIGIBLE FOR OR WILL NOT APPLY FOR MEDICAID;

B) DENY OR DELAY ADMISSION OR READMISSION OF A PERSON TO A NURSING HOME BECAUSE OF HIS OR HER STATUS AS A MEDICAID RECIPIENT;

C) TRANSFER A RESIDENT WITHIN THE NURSING HOME BECAUSE OF HIS OR HER STATUS AS A MEDICAID RECIPIENT;

D) TRANSFER A RESIDENT TO ANOTHER NURSING HOME BECAUSE OF HIS OR HER STATUS AS A MEDICAID RECIPIENT;

E) DISCHARGE OR TRANSFER A RESIDENT FROM A NURSING HOME BECAUSE OF HIS OR HER STATUS AS A MEDICAID RECIPIENT; OR

F) CHARGE ANY AMOUNTS IN EXCESS OF THE MEDICAID RATE FROM THE DATE OF ELIGIBILITY.

NATIONAL TRAINING STANDARDS FOR NURSING ASSISTANTS

THE IMPORTANCE OF NURSE AIDE TRAINING TO QUALITY RESIDENT CARE CANNOT BE OVERSTATED. NURSING ASSISTANTS DELIVER MORE THAN EIGHTY PERCENT OF RESIDENT CARE. THE FEDERAL GOVERNMENT SHOULD MANDATE NATIONAL TRAINING STANDARDS FOR NURSING ASSISTANTS. IT IS NOT EXPENSIVE. IN OUR STATE, THE COST OF TRAINING A NURSING ASSISTANT IS ABOUT ONE HUNDRED DOLLARS, OF WHICH FIFTY DOLLARS IS PAID BY THE FEDERAL GOVERNMENT. WHEN A SIGNIFICANT NUMBER OF NURSING ASSISTANTS ARE TRAINED, THE COST SUBSTANTIALLY

DIMINISHES. THE QUALITY OF CARE AND QUALITY OF LIFE FOR NURSING HOME RESIDENTS WILL SUBSTANTIALLY IMPROVE AS A RESULT OF TRAINING REQUIREMENTS.

NATIONAL ACADEMY OF SCIENCES' REPORT ON NURSING HOMES

THE REPORT, ENTITLED IMPROVING THE QUALITY OF CARE IN NURSING HOMES, RECOMMENDS STRENGTHENING THE NURSING HOME REGULATORY SYSTEM. CONGRESS ASKED HHS TO CONTRACT THE STUDY, FOLLOWING THE PUBLIC OUTCRY AFTER HHS MOVED TO REDUCE REGULATION OF THE NURSING HOME INDUSTRY IN 1982.

MY COLLEAGUES ACROSS THE NATION AND I CONCUR THAT DEREGULATION OF THE NURSING HOME INDUSTRY IS ILL-ADVISED AND THAT THE CURRENT FEDERAL REGULATORY SYSTEM IS DEFICIENT. NEEDED IS A REGULATORY SYSTEM THAT IS OUTCOME-ORIENTED AND RECOGNIZES THERE MAY BE MORE THAN ONE APPROACH TO ACHIEVING DESIRED RESULTS, BOTH IN THE PROVISION OF PATIENT CARE AND THE ADMINISTRATION OF STATE REGULATORY PROGRAMS. OF COURSE, SOME UNIFORMITY IN APPROACH IS REQUIRED AND DESIRABLE. THE ISSUE IS ONE OF REASONABLE BALANCE.

THE ACADEMY'S REPORT RESULTS FROM THE FIRST COMPREHENSIVE LOOK AT FEDERAL NURSING HOME REQUIREMENTS IN OVER A DECADE. IT PROVIDES A NEEDED FRAMEWORK FOR IMPROVING THE QUALITY OF LIFE FOR NURSING HOME RESIDENTS. IT

IS IMPERATIVE HHS ADOPT A SYSTEMATIC AND COOPERATIVE APPROACH TO IMPLEMENTING FEDERAL PROGRAM CHANGES IN THE FEDERAL MEDICAID PROGRAM. HHS MUST INVOLVE CONSUMER, PROVIDER AND STATE REPRESENTATIVES IN PLANNING, DEVELOPING AND IMPLEMENTING PROGRAM CHANGES. WE ARE THE CHANGE AGENTS WHO MUST FINALLY IMPLEMENT CHANGES. STRATEGIC PLANNING WILL MAXIMIZE PROGRAM AND COST EFFECTIVENESS.

EXCEEDINGLY HARSH AUDIT PENALTIES

WASHINGTON AND OTHER STATES ARE EXPERIENCING AN INCREASING NUMBER OF SEVERE FINANCIAL PENALTIES FROM FEDERAL NURSING HOME UTILIZATION CONTROL AUDITS. THE AUDIT CRITERIA ARE SERIOUSLY FLAWED IN THAT THEY SIMPLY MEASURE WHETHER THERE IS A ONE HUNDRED PERCENT COMPLIANCE WITH PAPER AND CALENDAR DATE REQUIREMENTS. IF A SINGLE PATIENT IN A FACILITY IS NOT REVIEWED BY A SPECIFIC DATE OR A PAPER REQUIREMENT NOT MET, THEN THE ENTIRE FACILITY IS OUT OF COMPLIANCE.

THE FEDERAL GOVERNMENT THEN LEVIES A SEVERE FINANCIAL PENALTY AGAINST THE STATE. THE ENTIRE MEDICAID POPULATION IS USED TO COMPUTE THE PENALTY. THIS IS TRUE EVEN IF THE CARE AND SERVICES BEING PROVIDED ARE SUPERIOR. THE PENALTIES ARE SO DRACONIAN THE AUDITS HAVE COME TO BE VIEWED AS A REVENUE TRAP AGAINST THE STATES. THESE PENALTIES TRANS-

LATE INTO LESS DOLLARS AVAILABLE TO MEET THE LEGITIMATE NEEDS OF MEDICAID RECIPIENTS. ATTACHED IS PROPOSED LANGUAGE WHICH ESTABLISHES A REASONABLE PENALTY PROVISION.

THANK YOU FOR THIS OPPORTUNITY TO CONTRIBUTE TO IMPROVING THE QUALITY OF CARE AND THE QUALITY OF LIFE FOR NURSING HOME RESIDENTS.

ATTACHMENTS:

(1) PROPOSED AUDIT PENALTY PROVISION

(2) LETTER TO THE HEALTH CARE FINANCING ADMINISTRATION FROM THE ASSOCIATION OF HEALTH FACILITY LICENSURE AND CERTIFICATION DIRECTORS REGARDING THE NEW FEDERAL NURSING HOME INSPECTION PROCESS

(3) MEMO TO STATE LICENSURE AND CERTIFICATION DIRECTORS FROM THE NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

Section 1903 (g) (5) Social Security Act

(5) In the case of a state's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in calendar quarter, the per centum amount of the reduction of the state's federal medical assistance percentage for that type of services under paragraph (1) ~~is-equal-to~~ shall be calculated as follows: 33 1/3 per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the state plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter. Where the amount of reduction thus calculated is 5 per centum or less, no reduction shall be made. Where the calculated reduction exceeds 5 per centum, a reasonableness factor of .05 shall be subtracted from the product.

Shirley M.
Carlton A.
Sid Ohm
Dewey M.
Lou Ehrlich
Chuck Harding
John Stilp
(return(2)

Association of Health Facility Licensure and Certification Directors

December 4, 1985

Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-119-P, P. O. Box 26676
Baltimore, Maryland 21207

Dear Administrator:

The Association of Health Facilities Licensure and Certification Directors appreciates the opportunity to comment on the proposed rule relating to Medicare and Medicaid Programs; Long-Term Care Survey, which was published in the Federal Register on October 31, 1985.

As the managers in the State Survey Agencies to which devolves the responsibility for implementation of health facility survey and certification programs, AHFLCD has within its ranks virtually all of the collective expertise and experience in application of those systems at the State level. We are confident, therefore, that input from this group will be carefully considered.

We applaud and support the concept of focusing on resident needs and describing the degree to which those needs are met by the facility as a function of compliance with certification requirements. As known to us on November 15, 1985, the proposed outcome-oriented PaCS survey instrument does represent the initiation of desirable changes in the current survey process. However, as a result of considerable discussion during the November Annual Meeting, it was unanimously determined that AHFLCD support of the PaCS system as currently proposed, is contingent upon its revision to include the following elements:

(1) that the final form of any changes take into consideration recommendations forthcoming from the Institute of Medicine and other academic, contracted, or pilot project studies;

(2) that the Health Care Financing Administration publish survey forms, interpretive guidelines and general instructions and make same available for general comment as part of the Notice of Proposed Rule Making or other process prior to implementation;

(3) that the Health Care Financing Administration develop and announce detailed training plans for administrative and survey staff that will promote excellent and consistent implementation and administration of the revised process;

(4) that the proposed survey process include a sampling methodology and comprehensive standardized patient assessment procedure that will merit a high degree of confidence in survey findings and will successfully withstand critical professional and legal scrutiny; and

(5) that any proposed changes in the current survey system respect state-to-state variations existent between survey and certification activities and inspection of Care programs and that appropriate funding is assured in the face of such changes.

The opportunity to modify the current system is welcomed and appreciated to the extent that we can participate as partners in constructive dialogue and advocate for changes that will provide for a process that will enhance our ability to measure service delivery to beneficiaries. It is our opinion that such an outcome can best be achieved by convening a work group comprised of knowledgeable consumers, providers, and regulators charged with the responsibility to discuss concerns and to develop implementation strategies commensurate with the human and financial commitments required for an undertaking of this magnitude.

Sincerely,

John J. Jarrell,
President
c/o Health Facilities Evaluation Division
West Virginia Department of Health
1800 Washington Street, East
Charleston, West Virginia 25305

cc: Fay Iudicello
Office of Information and Regulatory Affairs
Office of Management and Budget
Room 3208, New Executive Office Building
Washington, D.C. 20503

bc: AHFLCD Membership
Sharon Harris
Thomas Vernon, M. D.
Elma Holder

National Citizens' Coalition for
NURSING HOME REFORM

Elma Holder, Executive Director
Freida Gorecht, President

1424 16th Street, N.W.
Suite L2
Washington, DC 20036
202-797-0657

April 16, 1986

TO: State Licensure and Certification Directors
FROM: Elma Holder and Barbara Frank, NCCNHR
RE: New Long Term Care Survey Process and Institute of Medicine Report

New Long Term Care Survey Process

We sent the enclosed Statement of Concerns, with 20 co-signers, to Sharon Harris on April 9, 1986. As indicated in our comments of December, 1986 in response to the NPRM, we support implementation of the new survey process, however we continue to be concerned about the implementation process. Our major concerns regard: (1) sufficient time for states to make the necessary adjustments for a transition to the new system; (2) adequate training for surveyors; (3) better guidelines for surveyors; (4) better cooperation with states that have systems equal to or better than the federal process. We are also developing a letter, which we will share with you, addressing specific concerns about training, based on our observation of the first HCFA training on the new survey process, in Baltimore in February.

Our goal is to support implementation of the new survey process in the most constructive manner possible in order to put in place the best possible protections for nursing home residents. We need your assistance to provide comprehensive information to those interested in this goal. Please answer the enclosed questionnaire to the best of your ability and return it to us by May 9, so we can present this information to members of Congress, concerned national organizations and others during the public discussions about nursing home regulation this spring and summer. This survey has been reviewed by Jerry Jarrell.

We realize this is a short time frame for completion of our request. If you need to call with information and send further details later, you can reach us at (202) 797-0657. We recognize that this survey will take time and effort. Thank you for your assistance. The results will be shared with each state agency later this spring.

Finally we take this opportunity to encourage you to work with your state and local ombudsman programs, citizens groups and residents councils, especially during this implementation period. Many of these groups are anxious to hear how you plan to implement the new survey process and anxious to assist in community education, preparation of residents, and surveyor training, particularly in the areas of communication skills and residents rights. Concerns of residents about retaliation for their participation in the survey would be useful to discuss with these groups. They are interested in knowing about your plans and concerns, and assisting wherever possible.

Institute of Medicine Report

The report of the Institute of Medicine's Study Committee on Nursing Home Regulation is now available for $24.95 from National Academy Press, 2101 Constitution Ave., N.W. Washington, D.C., 20014; (202) 334-3313. The report, entitled Improving the Quality of Care in Nursing Homes, lays the groundwork for significant improvements in the nursing home regulatory system. NCCNHR convened a meeting on April 2 with national organizations, (Jerry Jarrell attended) to begin review of the report. Organizations agreed to work in cooperation on implementation of the recommendations. We'll continue to communicate with you as this progresses and look forward to hearing more of your comments.

Thank you again for your assistance. Best wishes!

National Citizens' Coalition for
NURSING HOME REFORM

Elma Holder, Executive Director
Fredo Gorlech, President

1424 16th Street, N.W.
Suite L2
Washington, DC 20036
202-797-0657

April 9, 1986

STATEMENT OF CONCERNS

RE: HCFA'S NEW LONG TERM CARE SURVEY PROCESS (PaCS)

TO: Sharon Harris, Acting Director
Office of Survey and Certification
Health Standards and Quality Bureau, HCFA

We are writing to express concerns about the implementation of the new Long Term Care Survey Process. We commend HCFA for initiating this important change in the way nursing homes are surveyed. HCFA's new long term care survey process is a positive and significant development in nursing home regulation. If implemented properly, it can tremendously strengthen HCFA's ability to monitor and assess the quality of care nursing home residents receive.

We support the process because it provides the opportunity to hear directly from residents about the quality of care and life in the homes. It focuses on the care residents actually receive rather than a home's compliance, in theory, with standards of good practice.

We recognize your agency's unprecedented efforts to share information about this new process and to solicit and incorporate recommendations for improvements. This openness has created an atmosphere for sincere discussion about how to develop a system that will best serve nursing home residents. We commend your proposed work plan which indicates continued agency activities which will contribute to an improved survey process. It is in the spirit of cooperation that we offer concerns and recommendations related to successful implementation of the new long term care survey process.

To be implemented and utilized successfully, this landmark change in nursing home regulation will require tremendous support and cooperation from federal and state regulatory agencies, nursing home providers and residents, and their representatives.

We recognize that it took a great deal of time and thought to develop this new system. Now the Health Care Financing Administration is endangering this new system with a poorly developed, unrealistic and potentially harmful implementation plan including:

(1) an unrealistic implementation schedule. States need more than two or three months to make the transition to the new procedures, format and skills required by the new system. HCFA is to be commended for postponing start-up until 30 days after publication of a Notice of Final Rule which it expects to publish by the end of April. A June start-up is much more reasonable than the planned April 1 date. However, HCFA is requiring that states totally assimilate the new process within two months of start-up.

(2) an inadequate approach to training. HCFA is training less than 10% of those who will conduct the new survey and relying on those representatives to return to their states and convey new federal policies and procedures to their co-workers. States will have to purchase training materials and duplicate training manuals in order to provide the basic orientation to their surveyors. The training itself lacks sufficient development in the area of communicating with confused (or those who appear confused) residents and with residents who manifest communication difficulties, yet such communication is essential if the new process is to work.

(3) incomplete guidelines and instructions to surveyors. Current surveyor guidelines, in draft form, are confusing and incomplete, and particularly weak in the areas of residents' rights, residents' social, emotional, and mental health needs and other quality of life areas. HCFA has acknowledged these problems and is revising the guidelines. Although surveyors must begin conducting these new surveys in June, revised guidelines for the survey process will not be completed until October 1.

(4) inadequate recognition of and cooperation with positive innovations and activities of state regulatory agencies. Many states already conduct resident focused, outcome oriented surveys and have a broader range of enforcement tools available to apply to poor homes. HCFA has told state agencies to follow the federal format and procedures without exception, or lose federal financial participation, and has expressed an unwillingness to coordinate with effective state enforcement practices.

We, the undersigned organizations, call upon the Health Care Financing Administration to give the leadership and support necessary to help this system work for the protection and welfare of nursing home residents, by taking action to:

(1) establish a reasonable phase-in period for implementation of this new process, beginning June 1 and continuing through December 31, 1986;

(2) provide direct federal training to every surveyor, to assure consistent direction and clear statements of federal policy;

(3) develop a plan for follow-up training beginning in January, 1987, and to supply training materials for every surveyor and each state agency, particularly in the areas of communication skills, residents' rights, residents' social, emotional and mental health needs, and determining what is a deficiency;

(4) maintain its commitment to revise surveyor guidelines based on the experiences and concerns of surveyors, providers, health care professionals, and consumers after all have had experience with this new process;

(5) allow waivers to states whose innovative survey methods and enforcement practices exceed federal requirements, and to develop a process for approving waivers and reviewing them on a time-limited basis, with participation from regulators, providers, and consumers;

(6) work in partnership with regulators, providers and consumers to educate the public and maximize public participation in and understanding of the process;

(7) establish a task force of regulators, providers, health professionals, and consumers to monitor implementation and evolution of this new system and assist in development of training materials, surveyor guidelines and public education activities.

This new process is an evolutionary one. If implemented correctly, it can contribute to the many reforms in the system that are necessary reforms that are addressed in the March, 1986 Institute of Medicine report.

Changes in the way surveyors conduct surveys will require changes in approach, in attitudes, in skills, and in experience. These changes are much too important to be lost by shortcuts during this critical implementation period.

Co-signers of the Statement of Concerns

American Association of Homes for the Aging
American Association of Retired Persons
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Health Care Association
American Nurses Association
American Occupational Therapy Association
American Psychological Association
American Society of Consultant Pharmacists
National Association of Area Agencies on Aging
National Association of Social Workers
National Association of State Long Term Care Ombudsman Programs
National Association of State Units on Aging
National Citizens' Coalition for Nursing Home Reform
National Committee to Preserve Social Security and Medicare
National Consumers League
National Council of Senior Citizens
National Support Center for Families of the Aging
Service Employees International Union
Unitarian Universalist Association

MEDICAID UTILIZATION CONTROL PENALTIES LEVIED BY HCFA TO
THE REPRESENTATIVE STATES OF THE SENATE SPECIAL COMMITTEE ON AGING

DATA COMPILED FROM HCFA'S BUREAU OF QUALITY CONTROL
"MEDICAID UTILIZATION CONTROL PENALTIES"
JANUARY 1977 THROUGH DECEMBER 1984

STATE	PERIOD	LEVEL OF CARE	TOTAL AMOUNT OF PENALTY	
ARKANSAS	1/80-3/80	SNF	$12,251.34	
ARKANSAS	7/83-9/83	SNF	$114,862.63	*
ARKANSAS	4/83-6/83	SNF/ICF	$157,986.76	
ARKANSAS	10/84-12/84	MH	$74.34	*
ARKANSAS	1/84-9/84	ICF,ICF/MR,MH	$383,421.02	*
CALIFORNIA	10/83-12/83	ICF	$244,784.49	*
CONNECTICUT	7/83-9/83	SNF	$104,385.55	
FLORIDA	1/84-9/84	SNF,ICF,ICF/MR	$387,490.92	*
FLORIDA	4/82-6/82	SNF/ICF	$125,536.22	
LOUISIANA	1/84-9/84	ICF,ICF/MR	$462,429.75	*
LOUISIANA	10/82-6/83	ICF	$840,232.82	
LOUISIANA	7/83-9/83	ICF,ICF/MR	$31,711.38	
MAINE	7/82-9/82	ICF	$87,666.64	
NEW JERSEY	7/83-9/83	SNF	$3,587.95	
NORTH DAKOTA	7/78-9/78	SNF	$55,090.00	
OHIO	1/84-9/84	SNF,ICF,ICF/MR	$289,837.17	*
OHIO	7/78-9/78	SNF	$123,807.00	
OHIO	4/79-6/79	MH	$438,970.71	
OHIO	10/80-6/81	ICF/MR	$1,194,130.38	
OHIO	4/83-6/83	ICF/MR	$11,567.82	
OKLAHOMA	10/83-12/83	ICF	$232,567.49	*
OKLAHOMA	10/82-6/83	ICF	$165,850.97	
OKLAHOMA	7/80-9/80	ICF	$181,991.68	
PENNSYLVANIA	1/84-9/84	SNF,ICF,ICF/MR	$716,112.00	*
PENNSYLVANIA	4/82-6/82	ICF/SNF	$488,348.16	
SOUTH DAKOTA	1/80-3/80	SNF	$8,921.14	
SOUTH DAKOTA	1/84-9/84	ICF,ICF/MR	$36,537.00	*
SOUTH DAKOTA	4/82-6/82	SNF	$4,049.55	
VIRGINIA	10/83-12/83	ICF	$292,732.28	*
VIRGINIA	1/84-9/84	SNF,ICF,ICF/MR,IMD	$315,526.84	*
VIRGINIA	1/80-3/80	SNF	$19,022.14	
WASHINGTON	7/80-9/80	ICF,ICF/MR	$102,163.09	
WASHINGTON	1/84-9/84	SNF,ICF,ICF/MR	$334,400.39	*
WASHINGTON	7/82-9/82	ICF	$15,016.79	
WASHINGTON	4/82-6/82	SNF	$172,506.60	
	TOTALS		$8,115,371.01	

* PENDING REVIEW BY DHHS' GRANT APPEALS BOARD

Association of Health Facility Licensure and Certification Directors

May 21, 1986

Dear Reader:

The Association of Health Facility Licensure and Certification Directors supports the Institute of Medicine (IOM) report released by the National Academy of Sciences. The report, pertaining to nursing homes, is the first comprehensive review of federal nursing home requirements in over a decade. The report's recommendations provide a needed framework for improving the quality of life and care for nursing home residents. It is vitally important that a systematic approach be adopted for implementing program changes. Stategic planning will maximize both program and cost effectiveness.

The U.S. Department of Health and Human Services is the entity responsible for planning, developing and coordinating implementation of federal program changes. It is essential that consumers, providers and state regulators be involved in these efforts. We are the change agents who must finally implement program changes. Nursing home residents are the ultimate benefactors of a collective effort.

The attached statement is the Association's response to the recommendations made in the IOM report. If you desire further information or if we may be of assistance please write or call Conrad Thompson, Vice-President or me. We may be contacted at:

John J. Jarrell, Director
Health Facilities Evaluation Division
West Virginia Department of Health
1800 Washington Street, East
Charleston, West Virginia 25305
(304) 348-0050

Conrad Thompson, Director
Bureau of Nursing Home Affairs
Department of Social & Health Services
623 8th Avenue, Southeast
Olympia, Washington 98504
(206) 753-5840

Sincerely,

John Jarrell /ET/
John J. Jarrell
President

attachment

Association of Health Facility Licensure and Certification Directors

Association Statement on the Report,

Improving the Quality of Care in Nursing Homes

by the National Academy of Sciences'

Institute of Medicine

Committee on Nursing Home Regulation

John J. Jarrell, President

AHFLCD

May 21, 1986

AHFLCD Issues Committee Members:
Ron Barth--Illinois
Juan Lopez--New Mexico
Brant Van Meter--Oklahoma
Dana Petrowsky--Iowa
Lou Remily--Wisconsin
George Warner--New York
Conrad Thompson--Washington, Chairperson

Association of Health Facility Licensure and Certification Directors

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BACKGROUND

The National Academy of Sciences recently released a report recommending regulatory reforms to federal nursing home requirements. The report, entitled "Improving the Quality of Care in Nursing Homes," was conducted by the Committee on Nursing Home Regulation which was appointed by the National Academy of Sciences' Institute of Medicine. The federal Department of Health and Human Services (HHS) was asked by Congress to contract for the study, following public outcry when HHS moved to reduce regulations for the nursing home industry in 1982. The report recommends strengthening the nursing home regulatory system.

POSITION STATEMENT

The Association of Health Facility Licensure and Certification Directors supports the thrust of the report. Deregulation of the nursing home industry is ill advised. A regulatory system that is patient outcome oriented and dynamic in nature is needed; one which emphasizes quality of care and quality of life for nursing home residents.

QUALITY CARE

The current federal conditions of participation relating to care focuses on disciplinary requirements; i.e. nursing, social service, and dietary conditions. The IOM Committee recommends reorienting the federal standards to concentrate on actual care

being provided. Residents should be involved in determining their care needs as much as possible. A new condition on quality of care should identify desirable resident outcomes of care, pertaining to functional status, physical well-being and safety, emotional well-being, social involvement and participation, cognitive functioning and resident satisfaction. Specifying desired outcomes is important because it focuses on the purpose of nursing home care.

QUALITY OF LIFE

Unlike other medical care settings, the nursing home is a place of residence. Both the IOM report and a study of quality of life as viewed by nursing home residents emphasize that quality of life is of major importance to residents, in addition to quality care. A report by the National Citizens Coalition for Nursing Home Reform, entitled A Consumer Perspective on Quality Care: The Residents' Point of View, best addresses quality of life. Residents indicate a number of factors which contribute to the quality of life include:

- a supportive, comfortable, homelike environment
- a choice of surroundings, schedules, health care, menus, and activities
- treatment with dignity and respect
- opportunities to interact with family members and community members inside and outside the nursing home, an
- well-trained qualified workers.

The federal regulations currently do not address quality of life. A new condition of participation concerning quality of life should be added to the certification requirements.

RESIDENT ASSESSMENT

A standardized resident assessment system is essential to evaluate the care needs of each resident upon admission in order to develop an individual plan of care. Periodic reassessments are necessary to monitor changes in the resident's health and to modify the care plan. A resident assessment system contributes to:

- o determining case-mix and patient outcomes
- o determinining the need for care and services required through utilization review
- o establishing Medicaid reimbursement (for states which utilize case-mix as a factor in Medicaid payment)
- o evaluating Certificate of Need and planning
- o determining staffing needs
- o estimating future costs of care, and
- o determining effectiveness of nursing home management of care delivery.

Standard resident assessment data should be part of a database for use by the state and federal governments.

To effectively implement resident assessment, the necessary data and methods of collection must be clearly defined. Residents should be involved in the assessment process and adequate

training must be provided to qualified staff. Assessing residents functional capacity and care needs requires the skills of several health care professionals; including nurses, physicians, therapists and social workers. The validity of a nursing home's resident assessments requires careful monitoring by qualified, professional staff not associated with the home. HHS should initiate training programs for facility and state staffs. This will ensure that resident assessment data is collected and monitored in a consistent manner. The state regulatory agency or their designee should audit the home's resident assessments.

REMOVAL OF ICF/SNF CERTIFICATION DISTINCTION

A single set of certification standards for ICF/SNF nursing homes is advisable. The care needs of residents in these settings now cannot be clearly distinguished. Separate sets of federal certification criteria serve as a barrier to relocating patients. Intermediate Care Facilities are reluctant to transfer a resident needing the nursing care provided by an SNF because relocation could be traumatic to the resident. A single criteria should better assure the health and safety of all residents. Additional licensed nursing staff should be required to provide increased supervision and monitoring of nurse aides, resident assessments, and directing and supervising care services.

RESIDENT'S RIGHTS

The current federal standard pertaining to resident rights is unclear and lacks enforcement capability. The standard needs clarification. A new condition of participation is warranted to ensure a resident's right to receive equitable treatment, necessary information, reasonable choices and should require that residents be:

- o informed of legal rights
- o able to contact the state survey office
- o permitted to participate in the development of facility policies and personal care plans
- o assured access to survey reports and plans of correction
- o permitted to inspect their medical and social records
- o given prior notice of transfer, discharge, or expiration of bed hold
- o given the opportunity to participate in resident councils, advisory committees and family councils, and
- o given the opportunity to participate in social, religious, and political activities, and have private visits with persons of choice.

Resident rights are important and deserve to be addressed in a separate condition. The new condition should also recognize the rights of the cognitively impaired and by requiring that residents rights devolve to the patient's guardian or responsible party.

ADMINISTRATION

The IOM report advocates incorporating seven existing conditions into one condition entitled "Administration." The existing conditions of governing body and management, utilization review, transfer agreements, disaster preparedness, medical direction, laboratory and radiological services, and medical records would be combined together as standards under one condition. The condition should also mandate nurse aide training, prohibit discrimination, allow resident particicipation in facility decision-making, and assure access by ombudsmen and consumer advocates to the nursing home.

Nurse aide training should be added as a standard to the administration condition to require that all nurse aides complete an approved training program. Training of nurse aides is critically important to quality care. Nearly 80% of the care delivered to nursing home residents is provided by nurse aides. Given the predominance and importance of their role, effective on-going training programs are essential to quality resident care.

A new standard prohibiting discrimination needs to be part of the condition of administration. Because there are more people seeking admissions to nursing homes than there are beds available, nursing homes may select residents requiring minimal care, rather than heavy care residents. Providing care for patients requiring lighter care needs is less costly. There is a

financial incentive to admit a private pay resident rather than a Medicaid patient and to evict residents once they have exhausted their private funds. Discrimination must not be permitted to occur in facilities that participate in government programs. This nation's most frail, vulnerable citizens should not have to fight discrimination in addition to the aging process.

A standard requiring nursing homes to permit access by local area ombudsmen and consumer advocates should be part of the condition of administration. They are especially important to residents without visitors, family or friends. Community area advocates can serve as a resident's ally in negotiation or serve as a third party mediator. They may also serve as a conduit of consumer information to nursing home professionals and to regulatory agencies. Because of their orientation and scope of their responsibilities, the existing requirements pertaining to community area advocates should be improved.

SOCIAL SERVICES

Social services are essential in promoting quality of life and in improving social and psychological services for residents. Together, activities programs and social service programs can help residents take advantage of social, mental health, legal, educational, recreational, and spiritual affiliations in the community.

Social services requirements should be upgraded to require that each home with 100 beds or more employ at least one full-time social worker. For those homes with less than 100 beds, a minimum level (i.e. three-quarter FTE) of social services would need to be established. Upgrading the social service condition will improve the quality of life for nursing home residents.

QUALIFIED NURSING PERSONNEL

The IOM report recommends that nursing homes place their highest priority on the recruitment, retention, and support of adequate numbers of professional nursing staff. Qualified nursing personnel is a key factor indicating the quality of resident care. Yet, nursing homes generally experience high turnover rates among nursing staff. Although the AHFLCD recognizes that these high attrition rates may be associated with poor working conditions, heavy resident workloads, inadequate training, turnover rates may also be associated with insufficient wages or fringe benefits.

Generally, the wages for professional nursing staff and nurse aides in nursing homes are substantially below the wages paid by hospitals. Nursing homes should be encouraged to pay comparable wages to attract and retain qualified staff. Quality care and quality of life cannot be achieved unless nursing homes are able to recruit, retain and ensure that adequate numbers of nursing staff are provided to residents.

THE SURVEY PROCESS

The federal certification survey system needs to be redesigned to measure actual patient care and the quality of life. The present federal survey system does not assess quality care. It addresses the home's capacity to provide care and compliance with paper requirements. The evaluation of resident care should focus more on the resident rather than on paperwork review. Proper training of surveyors is critically important. The IOM report contains the following recommendations relating to survey:

- Consolidate Medicaid and Medicare survey procedures
- Timing of surveys should maximize the element of surprise. The elimination of time-limited agreements to permit flexibility in scheduling surveys
- Design and test two survey protocols; a standard survey and an extended survey
- Incorporate information on case-mix as derived from resident assessment data into survey protocols to take into account the differing characteristics
- A scientific sample of residents by case-mix; for both standard and extended surveys
- Survey residents using "key indicators" which measure actual services provided
- Require extended surveys for nursing homes which perform poorly on key indicators
- Emphasize interviews and observations of residents in assessing quality
- Require specific procedures and staff to properly investigate complaints of abuse and neglect
- Require HHS to establish additional survey procedures which require surveyors to meet with resident representatives before and after survey; that survey results be posted in a location accessible to residents and the public

- o Recognize facilities providing excellent resident care
- o Design survey protocols in accordance with recommended conditions and standards
- o Test survey protocols (instruments and procedures) for validity, and
- o Subject a sample of nursing homes to an extended survey.

The survey process should be modified to emphasize the recommended resident-centered, outcome-oriented standards proposed in the IOM report. The survey process needs to be redesigned to consider the differing care requirements of each patient, outcome and process measures of quality care, and consumer involvement. Surveys should be unannounced and maximize the element of surprise.

HHS has developed a new long term care survey process, formerly entitled PaCS (for Patient Care and Services). Briefly, the Long Term Care Survey Process evaluates the provision of services and resident outcomes by:

- o observing the physical environment
- o reviewing care provided to a sample of residents
- o observing meal services
- o observing drug administration for a sample of residents

The Long Term Care Survey Process is an improvement over the traditional federal survey process. It focuses on resident outcome rather than facility capacity and compliance with paper requirements. There remain, however, serious deficiencies in the new Long Term Care Survey Process survey system. Our support of

the Long Term Care Survey Process system as currently proposed is contingent upon its revision to include the following elements:

- that the final form of any changes take into consideration the recommendations contained in the IOM report and other studies
- that HHS publish survey forms, interpretive guidelines and general instructions and make same available for general comment as part of the Notice of Proposed Rule Making or other process prior to implementation
- that HHS develop and announce detailed training plans for administrative and survey staff that will promote excellent and consistent implementation and administration of the revised process
- that the Long Term Care Survey Process include a sampling methodology and comprehensive standardized resident assessment procedure that will merit a high degree of confidence in survey findings and will successfully withstand critical professional and legal scrutiny
- that the Long Term Care Survey Process respect state-to-state variations existing between survey and certification activities and inspection of Care programs and that appropriate funding is assured in the face of such changes
- that HHS allow waivers to states whose innovative survey methods and enforcement practices exceed federal requirements, and develop a process for approving waivers and reviewing them on a time-limited basis, with participation from regulators, providers, and consumers, and
- that a task force comprised of regulators, providers, health professionals and consumers monitor implementation and evolution of the Long Term Care Survey Process and assist in development of training materials, surveyor guidelines and public education activities.

The opportunity to modify the current system is welcomed. A constructive and collective effort on the part of the state and federal governments will provide for a process that will enhance our ability to measure service delivery to nursing home residents.

The integration of federal utilization control requirements with survey deserves careful consideration. A review by HHS is advisable and should involve states with superior waivers, and their experiences with unique systems.

FUNDING

The IOM report did not estimate the cost of the recommendations pertaining to elimination of the ICF designation, implementing a resident assessment system, strengthening the Ombudsman program, and redesigning the survey process.

The integrity of the nursing home survey process is dependent upon adequate funding. Presently, less than one percent of the federal Medicaid budget goes to fund nursing home inspections. The 1986 federal Medicaid budget for the entire nation is only forty-four million dollars. We concur with the recommendation of the IOM report which calls for reinstituting one hundred percent federal funding for nursing home certification inspections.

The Gramm-Rudman Act, and other efforts to reduce government spending, has ominous implications for the states' ability to perform surveillance. HHS is presently implementing cuts to selected state survey and certification budgets, consistent with the first round 4.3% spending reduction mandated by Gramm-Rudman. If implemented, Gramm-Rudman Round II would call for a further reduction of twenty-three percent.

We are very concerned about the present proposal to reduce federal matching funds for Medicaid program administration, in addition to further budget cuts. To reduce survey budgets now, when the federal government is mandating a new national survey process which requires additional resources, poses the gravest consequences for the nation's ability to monitor health care.

ENFORCEMENT OPTIONS

Federal Medicaid program requirements should include an effective array of enforcement sanctions. It is not in the best interests of nursing home residents that the only federal sanction is cancellation of the Medicaid contract. A contract cancellation forces the relocation of Medicaid residents, punishing the wrong party. Sanctions will assist the state and federal government in assuring quality care for nursing home residents. Sanctions needed are:

1. A Ban on Admissions. When resident care is substandard, a ban on admissions is a valuable enforcement tool. New admissions require a substantial amount of work. The ban protects the health and safety of residents by forcing the facility to target resources toward correction of deficiencies. Further, a ban on admissions creates a financial incentive and puts public pressure on the nursing home to achieve and maintain compliance with health and safety standards.

2. Civil Fines. Civil fines are an important enforcement option to program administrators. They have proven to be a valuable enforcement tool in numerous states.

3. Receivership. Receivership is a temporary action to protect the health and safety of residents. When a nursing home cannot meet the care needs of its residents, receivership permits the state to act as a manager of the home and as a trustee on behalf of residents until quality of care is restored.

HHS should be commended for its work to improve federal termination procedures. However, the procedures do not provide for appropriate responses to receivership actions or ownership changes. The problem is that, even if the nursing home provider is the source of the trouble and a new credible owner takes over, the new procedures still force the relocation of all Medicaid recipients.

HHS informs us the new procedures only apply to Medicare. Yet, they "recommended" the states use them in administering the Medicaid program. This ambiguity creates problems for the states. No federal regulations have been promulgated to apply these termination procedures to Medicaid. Moreover, the Medicare procedures are not consistent with Medicaid requirements. For example, they do no provide for an informal conference with the nursing home provider prior to termination, which is a clear requirement under the Code of Federal Regulations.

AUDIT CRITERIA

Federal officials have an oversight responsibility to ensure state programs operate within the broad statutory framework. This oversight is to ensure that service quality is adequate and that persons receiving services are eligible and have a medical need for services. However, federal Medicaid program audits have shifted away from helping states to improve care. The focus now is on citing technical deficiencies which result in severe financial penalties against the states.

The criteria for audits are seriously flawed: in that the audits simply measure whether there is one hundred percent compliance with thousands of paper and calendar date requirements. Anything less than one hundred percent compliance results in severe financial losses to the states. In our view, these penalties translate into less dollars available to meet the legitimate needs of Medicaid recipients. The current penalties are so draconian the audits have come to be viewed as a revenue trap against the states.

We recommend that federal requirements pertaining to paper compliance and calendar date requirements be modified to establish a five percent reasonableness level. In addition, HHS should provide prior written notice to states of new or modified criteria on which audits will be conducted and penalties assessed. We are anxious to work with HHS to improve the current requirement and to establish fundamentally sound audit criteria which relate to the ultimate outcome, quality patient care.

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FEDERAL/STATE COOPERATION

The AHFLCD believes that implementation of the recommendations requires a strong federal/state relationship. The states are responsible for certification and licensure surveys, certificate of need, rate setting, and consumer protection. The combined resources and experience of the states regulatory agencies and by HHS should be utilized in implementing changes. Nursing home residents are the ultimate benefactor.

We strongly urge the federal government to be flexible in permitting states to implement program changes by waiver. In fact, some of the recommendations contained in the IOM report find their roots in effective state program waivers, requested and implemented by individual states. Continuing the waiver process will allow states to modify systems based on experience and knowledge and can further improve the quality care and the quality of life for nursing home residents.

FOLLOWUP

The AHFLCD strongly recommends the establishment of a national level mechanism for followup of any major changes to Medicaid requirements. Several different mechanisms could be proposed:

1) Formation of a national oversight task force; guided by HHS

2) Creation of a Congressional "watch dog" committee

3) Creation of an ongoing task force; composed of consumer and provider groups, and state and federal regulatory agency representatives.

Chairman HEINZ. Mr. Thompson, thank you very much. You are quite an expert on this subject.

Let me just announce, before I call on Ms. Edelman to testify, that I am going to ask Senator Wilson to make any comments that he has. I am going to have to go to another responsibility I have at 11:30, and Senator Pryor has graciously consented to conclude the hearing. I cannot think of anybody who has been working in this area and on these issues longer than my friend, David Pryor, so it is entirely fitting that he do a little time in the chair.

He informs me, by the way, Mr. Lopez, that when he was working as an orderly in a nursing home, he on occasion saw a few things to almost compare to what you showed us. That just means, I guess, that we must still work on these problems very hard indeed.

So, Pete Wilson.

STATEMENT OF SENATOR PETE WILSON

Senator WILSON. Thank you very much, Mr. Chairman.

I will not delay Ms. Edelman long, and I regret that three other commitments this morning caused me to arrive here later than I had hoped I could, and I have to leave in about 5 minutes for yet another.

I am particularly interested to see the film that Mr. Lopez showed. The testimony we have just heard from Mr. Thompson, I think, was not only eloquent, but forceful, borne of clear conviction. He is proposing some additional sanctions that sound difficult, tough, but in light of what apparently are the nature of the abuses, they may well be called for.

I would only say that looking at the testimony that is before us in these notebooks, it is clear that we are facing what is a growing problem because of the happy consequence of improved medical care, prolonging life, but generating an evergrowing need for nursing home care.

The real question, it seems to me, is one that I have heard Mr. Thompson discuss in his testimony here, and that is the need for quality as well as quantity.

In terms of the personnel involved in inspecting, it seems to me that that is an area where there is going to have to be even more attention given.

I have one question that I will ask at the risk of being naive. It almost sounds as though it is not likely that we are going to have an adequate supply of personnel for the purpose. And that is borne of the fact that there seems to be an inadequate supply of personnel with what is a growing universe of nursing home care requirements.

How would you propose, any of you, that we meet that need? It is a question both of money, but it is also a question of just finding people. And is it realistic to incorporate to a greater degree than has been done already, in a systematic way, the use of volunteers for that purpose?

Ms. DOYLE. Can I say something? I think, I believe it was Mr. Thompson, who had the answer. If there is any one thing that I believe would have changed the quality of the nursing home care

that my mother received, it would have been having aides that were properly trained. There is a terribly high percentage of patient abuse that goes on unintentionally.

My mother's hand was neglected for that extended period of time, simply because her aides were not taught how to wash her hand while preventing my mother from taking her other hand and trying to pull at the aide and push her away.

Now, the process was not difficult. I finally figured out a way of doing it, and I washed her hand whenever I went. But why shouldn't her aides have known how to perform that task?

Also, regarding the contracture, all it needed to prevent mom's hand from further closing was for my mother's hand to be opened each day. This was the same kind of situation. It could have been done by the aide. Taxpayers did not need to pay for expensive physical therapy through Medicaid just to have someone open her hand. But because the aide was not trained to know how to do that or that it even should be done, mom's contracted hand was neglected to the point where it was almost amputated. This gap between mom's needs and her aides training affected much of mom's care . . . hanging a Foley bag above the waistline is another example, not realizing that such a move can cause serious problems.

There is nothing I found that could have improved Mom's care so much as well-trained aides. There is also not only the possibility of improving care by having aides properly trained and certified. I think if we Americans can apply our intelligence to things like working out systems for improved success in other businesses, why can't we work out systems for the business of providing nursing home care that will make the care of patients less expensive and more efficient, so that less people are needed to do the job? We desperately need improvement in the quality of nursing aide training.

Mr. LOPEZ. Senator Wilson, in California, there is a Certified Nurses Aide Program that commenced a couple of years ago. It is really new. It has in fact a basic requirement of training and other things that go with that. But even with that, our statistics show that in California there is over a 100-percent turnover in nurses aides even in nursing homes ranking up at the 75th percentile. So the remedy is something between an incentive ladder and something to get them to stay once trained. But on a national level, I would urge that the Certified Nurses Aide Program be strongly recommended or implemented, something along those lines. We have that.

Mr. THOMPSON. I believe your question had a larger scope, too, and that is, for example, in Washington State our occupancy rate is running 94 percent, which, for all intents and purposes, is full. We have before us demographics referred to as "the graying of America"—in my case, "the balding of America". The question is, How we are going to meet the growing needs of our elderly. With the advances in medical technology, people are living longer and staying healthier. They are going to live with more dignity if we can keep them in the most independent living setting possible. This means in retirement centers, congregate care facilities, at home with the meals-on-wheels programs, chore services and home health. It is important that we develop a full array of services in the continuum of long-term care. My testimony today deals more

specifically with resident care in the nursing home, but there is a scope far beyond that which I think your question reaches. If we expect nursing homes to meet demographic demands, there is not nearly an adequate supply of nursing home beds.

Senator WILSON. It does, you are quite correct, although what I was trying to focus on was is the kind of care in a nursing home such that it is impractical to expect that, let us say, college-age volunteers, seeking to, if not gain credit, at least do something worthwhile as volunteers, might be trained at a certain level and be a dependable enough source of supply of manpower to make the difference that it seems to me is a widening difference?

Mr. THOMPSON. There are some very helpful programs. In our State, one home, for example, is having high school students as a part of their civic responsibility spend time assisting in the nursing homes. And it was reported to be very helpful. And I believe that there is room—obviously, voluntarism is part of what makes America so great—and we need to involve volunteers.

A second program that has been helpful in a number of homes is operating daycare centers out of nursing homes. The elderly people just love it. Pet therapy is another example. During a visit to a nursing home, I was going down the hall and noticed a patient in the corner. She had been in the home 3 days. She was not talking to anybody or adjusting very well. I stopped and bent down to talk to this lady. She would not converse. I had just walked out of a patient's room who had a cat I had been petting. Suddenly this cat appeared and jumped in her lap. She sprung to life. She loved it and began talking.

Ms. CASPER. I would just like to follow up on that as well. I agree, there is definitely a role in the psychosocial, quality of life aspects, for voluntarism, but we must be careful to avoid the pitfall that, with the rising acuity level of residents and residents coming to long-term care facilities with extremely complex needs—people in nursing homes now that I never would have seen as a director of nursing 12 years ago—we must be careful that we do not allow untrained volunteer people to be allowed to enter into that arena.

Mr. THOMPSON. Yes; I agree.

Senator WILSON. Thank you, Mr. Chairman.

Senator PRYOR [presiding]. Thank you, Senator Wilson.

Our final witness on this panel, Toby Edelman, is representing the National Senior Citizens Law Center. We look forward to your statement, Toby.

STATEMENT OF TOBY EDELMAN, STAFF ATTORNEY, NATIONAL CITIZENS LAW CENTER, WASHINGTON, DC

Ms. EDELMAN. Thank you very much, Senator.

This morning I have been asked to discuss the landmark Federal case *Smith* v. *Bowen*. That case overturned the Federal nursing home enforcement system and called for the Department to develop a new system that ensures that residents receive high-quality care.

The *Smith* case was filed in May 1975 by two nursing home residents who sued their nursing home, the Colorado Departments of Health and Social Services, and the Federal Department of Health,

Education, and Welfare. The residents complained that the nursing home enforcement system fails to ensure that residents receive their entitlement under the Medicaid law to high-quality medical and psychosocial care in the context of full civil liberties.

In 1978, the Colorado defendants realigned themselves as plaintiffs and joined the nursing home residents in criticizing the Federal survey and certification system. The State plaintiffs called the Federal system, a national disgrace.

A trial was conducted against the Federal defendant in the spring of 1982, and a decision issued in February 1983. The district court recognized that the current system is appropriately characterized as facility-oriented rather than patient-oriented, focusing on the potential ability of a facility to provide care and not on the care actually provided to residents.

The court ruled that the evidence submitted at trial—both the voluminous exhibits and oral testimony—made clear that it is feasible for the Secretary to require States to use a different kind of system—a patient care management system that assesses patient needs and allows for monitoring of care actually received.

Despite these findings, the district court held that the Secretary does not have a statutory duty to compel use of such a patient-oriented system. The court found in essence that the Federal Government pays for care under the Medicaid Program, but that responsibility for the quality of that care lies solely with the States.

The court of appeals disagreed and reversed. In October 1984, the Tenth Circuit Court of Appeals held that the Secretary has a duty to establish a survey and certification system that enables her to inform herself adequately whether facilities receiving Federal money are complying with the law and providing high-quality medical care and rehabilitative services.

The tenth circuit decision makes two critical rulings: First, that there is a strong Federal duty to enforce compliance with the Medicaid law, and second, that the Medicaid law itself requires health care providers to give recipients high-quality medical care.

The Department's response to the Smith mandate was PACS, the new survey and certification system. The system is a new way of looking at facilities and of selecting information about them, and while there is generally universal support among consumers and providers for refocusing surveys on residents and the care they receive, the survey instrument and procedures have significant uncorrected problems.

For example, the guidelines do not tell surveyors how to translate the problems they observe into deficiencies they can cite. Nor do they explain how to select a representative sample of residents to interview indepth. Surveyor training is inadequate, and resident and public education on the new system is nonexistent.

The Committee on Nursing Home Regulation of the Institute of Medicine found other major deficiencies in the new survey protocol. Last month, 20 national organizations expressed continued concern with the new survey process. They urged the Department to establish a reasonable phase-in period for implementation; to improve initial and followup surveyor training; to revise the guidelines; to allow waivers to States with innovative survey methods and enforcement practices that exceed Federal requirements; and

to establish a task force of regulators, providers, health professionals and consumers to monitor implementation and evolution of the new system. I have provided the committee with a copy of this statement of concerns.[18]

Even if the new survey system were the perfect tool, it would not be sufficient to meet the mandate of the Smith court. The survey process is only one part of the nursing home system to assure high quality of care and life to residents. To comply with Smith, the system needs to have the following components. First, good standards of care, including a condition of participation on the quality of life, as the Institute of Medicine suggested; second, effective methods for surveying and determining the quality of service provided—that is what the PACS system is all about; third, solid enforcement procedures to eliminate bad practices and promote good ones. This component calls for a full range of Federal intermediate sanctions we have been talking about this morning, such as receivership, civil fines, monitors, and so forth; fourth, adequate reimbursement properly focused on quality care and services, accountable to public scrutiny; and fifth, active public participation.

These five recommendations were unanimously endorsed in December 1985 at a work session on PACS held by the National Citizens Coalition for Nursing Home Reform, a national organization that participated in the *Smith* case as a friend of the court. I have also provided the committee with that resolution.[19]

The Institute of Medicine, I would note, made virtually identical recommendations in its report 2 months ago.

The Department has known for many years that the nursing home survey system fails to assure high-quality care to residents. Much of the plaintiffs' evidence in the *Smith* case was studies that were either conducted or commissioned by the Department in recognition of the inappropriate facility-oriented paper compliance nature of the survey process. The new survey system, while a good and important first step in the right direction, is not the total answer to the Federal Government's responsibility.

The Department needs to do more to assure that long-term care facilities provide their residents with high quality of care and life.

Thank you.

Senator PRYOR. Thank you very much.

[The prepared statement of Ms. Edelman follows:]

[18] "Please see page 169."
[19] "Please see page 172."

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"NURSING HOME CARE: THE UNFINISHED AGENDA"

Hearing, U. S. Senate Special Committee on Aging
May 21, 1986

Thank you for the opportunity to testify before the Committee today. I shall very briefly answer the questions in the Committee's May 13th letter and expand upon the answers in written testimony that I shall submit for the record at a later time.

Smith v. Bowen was filed in May, 1975 by two nursing home residents who sued their nursing home, the Colorado Departments of Health and Social Services, and what was then known as the federal Department of Health, Education and Welfare. The residents complained that the federal nursing home enforcement system fails to ensure that residents receive their entitlement under the Medicaid law to high quality medical and psychosocial care in a context of civil liberties. In 1978, the Colorado defendants realigned as plaintiffs and joined the residents in criticizing the

federal survey and certification process. The state plaintiffs called the federal system "'a national disgrace.'" In re Estate of Smith v. O'Halloran, 557 F. Supp. 289, 291 (D. Colo. 1983) (quoting paragraph 1 of complaint of plaintiffs in intervention).

A trial was conducted against the federal defendant in the spring of 1982 and a decision issued in February, 1983. The district court recognized that the current system is appropriately characterized as "facility-oriented," rather than "patient-oriented," id., 557 F. Supp. at 295, focusing on the potential ability of a facility to provide care, not on the care actually provided. The court ruled that the evidence submitted at trial--both the voluminous exhibits and oral testimony--made clear that it is "feasible" for the Secretary to requires states to use a different kind of system--a patient care management system that assesses patient needs and allows for monitoring of care actually received. Id. Despite these findings, the court held that the Secretary does not have a statutory duty to compel use of such a patient-oriented system. The court found, in essence, that the federal government pays for care under the Medicaid program but that responsibility for the quality of that care lies solely with the states.

The Court of Appeals disagreed and reversed. In October, 1984, the 10th Circuit Court of Appeals held that

the Secretary has a duty to establish a survey and certification system that enables her to inform herself adequately whether facilities receiving federal money are complying with the law and providing high quality medical care and rehabilitative services to residents. Estate of Smith v. Heckler, 747 F.2d 583, 589-90 (10th Cir. 1984).

The Tenth Circuit decision makes two critical rulings: first, that there is a strong federal duty to enforce compliance with the Medicaid law; and second, that the Medicaid law itself requires health care providers to give recipients high quality medical care.

The Department's response to the Smith mandate was PaCS, an acronym standing for Patient Care and Services, a new survey and certification system now known simply as the Long-Term Care Survey Process. The system is a new way of looking at facilities and of collecting information about them. While there is universal support among consumers and providers for refocusing surveys on residents and the care they receive, the survey instrument and procedures have significant uncorrected problems. For example, the guidelines do not tell surveyors how to translate the problems they observe into deficiencies they can cite, nor do they explain how to select a representative sample of residents to interview in-depth. Surveyor training is inadequate and resident and public education on the new

system is non-existent. The Committee on Nursing Home Regulation of the Institute of Medicine found other major deficiencies in the new survey protocol, including the failure to require facilities to maintain standard resident assessment data. The Committee on Nursing Home Regulations, Institute of Medicine, Improving the Quality of Care in Nursing Homes, 130-32 (1986).

Last month, twenty national organizations expressed continued concern with the new survey process. They urged the Department to establish a reasonable phase-in period for implementation, to improve initial and follow-up surveyor training; to revise surveyor guidelines; to allow waivers to states with innovative survey methods and enforcement practices exceeding federal requirements; and to establish a task force of regulators, providers, health professionals and consumers to monitor implementation and evolution of the new system. (I have provided the Committee with a copy of the Statement of Concerns.)

Even if the new survey system were the perfect tool, it would not be sufficient to meet the mandate of the Smith court. The survey process is only one part of the nursing home system to assure high quality of care and life to residents. To comply with Smith, the system needs to have the following components:

1. good standards of care, including a condition of participation on the quality of life, as the Institute of Medicine suggested;

2. effective methods for surveying and determining the quality of service provided;
3. solid enforcement procedures to eliminate bad practices and promote good ones (this component calls for a full range of federal intermediate sanctions);
4. adequate reimbursement properly focused on quality care and services, accountable to public scrutiny; and
5. active public participation.

These five recommendations were unanimously endorsed in December, 1985, at a work session on PaCS held by the National Citizens Coalition for Nursing Home Reform, an organization that participated in the Smith case as a friend of the court. (I have provided the Committee with a copy of the Resolution.) The Institute of Medicine made virtually identical recommendations in its 1986 report.

The Department has known for many years that the nursing home survey system fails to assure high quality care to residents. Much of plaintiffs' evidence in the Smith case was studies conducted or commissioned by the Department, in recognition of the inappropriate "facility-oriented" nature of the survey process. The new survey system, while a good and important first step in the right direction, is not the total answer to the federal government's responsibility. The Department needs to do more to assure that long-term care facilities provide their residents with high quality of care and life.

Toby S. Edelman
May 19, 1986

National Citizens' Coalition for
NURSING HOME REFORM

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April 9, 1986

STATEMENT OF CONCERNS

RE: HCFA'S NEW LONG TERM CARE SURVEY PROCESS (PaCS)

TO: Sharon Harris, Acting Director
Office of Survey and Certification
Health Standards and Quality Bureau, HCFA

We are writing to express concerns about the implementation of the new Long Term Care Survey Process. We commend HCFA for initiating this important change in the way nursing homes are surveyed. HCFA's new long term care survey process is a positive and significant development in nursing home regulation. If implemented properly, it can tremendously strengthen HCFA's ability to monitor and assess the quality of care nursing home residents receive.

We support the process because it provides the opportunity to hear directly from residents about the quality of care and life in the homes. It focuses on the care residents actually receive rather than a home's compliance, in theory, with standards of good practice.

We recognize your agency's unprecedented efforts to share information about this new process and to solicit and incorporate recommendations for improvements. This openness has created an atmosphere for sincere discussion about how to develop a system that will best serve nursing home residents. We commend your proposed work plan which indicates continued agency activities which will contribute to an improved survey process. It is in the spirit of cooperation that we offer concerns and recommendations related to successful implementation of the new long term care survey process.

To be implemented and utilized successfully, this landmark change in nursing home regulation will require tremendous support and cooperation from federal and state regulatory agencies, nursing home providers and residents, and their representatives.

We recognize that it took a great deal of time and thought to develop this new system. Now the Health Care Financing Administration is endangering this new system with a poorly developed, unrealistic and potentially harmful implementation plan including:

(1) an unrealistic implementation schedule. States need more than two or three months to make the transition to the new procedures, format and skills required by the new system. HCFA is to be commended for postponing start-up until 30 days after publication of a Notice of Final Rule which it expects to publish by the end of April. A June start-up is much more reasonable than the planned April 1 date. However, HCFA is requiring that states totally assimilate the new process within two months of start-up.

(2) an inadequate approach to training. HCFA is training less than 10% of those who will conduct the new survey and relying on those representatives to return to their states and convey new federal policies and procedures to their co-workers. States will have to purchase training materials and duplicate training manuals in order to provide the basic orientation to their surveyors. The training itself lacks sufficient development in the area of communicating with confused (or those who appear confused) residents and with residents who manifest communication difficulties, yet such communication is essential if the new process is to work.

(3) incomplete guidelines and instructions to surveyors. Current surveyor guidelines, in draft form, are confusing and incomplete, and particularly weak in the areas of residents' rights, residents' social, emotional, and mental health needs and other quality of life areas. HCFA has acknowledged these problems and is revising the guidelines. Although surveyors must begin conducting these new surveys in June, revised guidelines for the survey process will not be completed until October 1.

(4) inadequate recognition of and cooperation with positive innovations and activities of state regulatory agencies. Many states already conduct resident focused, outcome oriented surveys and have a broader range of enforcement tools available to apply to poor homes. HCFA has told state agencies to follow the federal format and procedures without exception, or lose federal financial participation, and has expressed an unwillingness to coordinate with effective state enforcement practices.

We, the undersigned organizations, call upon the Health Care Financing Administration to give the leadership and support necessary to help this system work for the protection and welfare of nursing home residents, by taking action to:

(1) establish a reasonable phase-in period for implementation of this new process, beginning June 1 and continuing through December 31, 1986;

(2) provide direct federal training to every surveyor, to assure consistent direction and clear statements of federal policy;

(3) develop a plan for follow-up training beginning in January, 1987, and to supply training materials for every surveyor and each state agency, particularly in the areas of communication skills, residents' rights, residents' social, emotional and mental health needs, and determining what is a deficiency.

(4) maintain its commitment to revise surveyor guidelines based on the experiences and concerns of surveyors, providers, health care professionals, and consumers after all have had experience with this new process;

(5) allow waivers to states whose innovative survey methods and enforcement practices exceed federal requirements, and to develop a process for approving waivers and reviewing them on a time-limited basis, with participation from regulators, providers, and consumers;

(6) work in partnership with regulators, providers and consumers to educate the public and maximize public participation in and understanding of the process;

(7) establish a task force of regulators, providers, health professionals, and consumers to monitor implementation and evolution of this new system and assist in development of training materials, surveyor guidelines and public education activities.

This new process is an evolutionary one. If implemented correctly, it can contribute to the many reforms in the system that are necessary - reforms that are addressed in the March, 1986 Institute of Medicine report.

Changes in the way surveyors conduct surveys will require changes in approach, in attitudes, in skills, and in experience. These changes are much too important to be lost by shortcuts during this critical implementation period.

Co-signers of the Statement of Concerns

American Association of Homes for the Aging
American Association of Retired Persons
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Health Care Association
American Nurses Association
American Occupational Therapy Association
American Psychological Association
American Society of Consultant Pharmacists
National Association of Area Agencies on Aging
National Association of Social Workers
National Association of State Long Term Care Ombudsman Programs
National Association of State Units on Aging
National Citizens' Coalition for Nursing Home Reform
National Committee to Preserve Social Security and Medicare
National Consumers League
National Council of Senior Citizens
National Support Center for Families of the Aging
Service Employees International Union
Unitarian Universalist Association

National Citizens' Coalition for Nursing Home Reform

STATEMENT AND PRELIMINARY RESPONSE TO HEALTH CARE FINANCING ADMINISTRATION

Proposed Rules, October 31, 1985, Federal Register, Vol. 50, No. 211
File Code: HSQ-119-P

The National Citizens' Coalition for Nursing Home Reform, with support from the American Association of Retired Persons, conducted an 18-hour working session to review HCFA's PaCS proposal. Participants at the last day of the session, and subsequently, the NCCNHR Board of Directors, unanimously supported the resolution which follows. The resolution calls for a 60-day extension of the comment period to provide time to review the extensive materials necessary for reorganizing the survey process - many of which have only recently become available. It is important that the public have the opportunity to review and comment on these materials, just as HCFA has provided this opportunity for participants in the working session. The resolution views PaCS as an important step in the development of a sufficient survey-enforcement system, but one that is incomplete, in its present form, and is not now usable for certification purposes. The resolution also views PaCS in the context of the nursing home system and recommends significant changes in the total regulatory system before quality care for residents can be assured. NCCNHR urges HCFA-HSQB to continue to include consumers, providers, health care professionals, and other interested parties in the development of this system. HCFA-HSQB is to be commended for such activities thus far. A list of participants in the December 9-11, 1985 meeting is attached. (Participants who attended the final December 11 session are noted.)

RESOLUTION ON PaCS

Unanimously Supported by

Participants in the NCCNHR Work Session

December 11, 1985

and the NCCNHR Board of Directors

This resolution is passed in recognition and reaffirmation of the duty of the Secretary of the Department of Health and Human Services "to assure that standards which govern the provision of care in skilled nursing facilities and intermediate care facilities .... and the enforcement of such standards, are adequate to protect the health and safety of residents and to promote the effective and efficient use of public moneys." (as stated in Public Law 98-369, a 1984 amendment to the Social Security Act.)

According to the legislative background of this amendment, it is the intent of Congress that, "Protection of the 'health and safety of residents' and promotion of 'effective and efficient use of public monies' means that the Secretary must establish and enforce standards to achieve the goal of the Medicaid Act, that nursing home residents receive appropriate, high quality services to help individuals attain or retain capability for independence and self care."

PaCS in Context of the Nursing Home System

Assuring high quality care and services for nursing home residents requires a regulatory system with several essential components:

1) good standards of care

2) effective methods for surveying and determining the quality of service provided

3) solid enforcement procedures to eliminate bad practices and promote good ones

4) adequate reimbursement properly focused on quality care and services, accountable to public scrutiny

5) active public participation

A Consumer Statement of Principles for the Nursing Home Regulatory System, written by the National Citizens' Coalition for Nursing Home Reform and endorsed by 40 national and 250 state and local organizations, was submitted to the Secretary of the Department of Health and Human Services in September, 1983. This Statement of Principles elaborates the essential ingredients of an effective regulatory system, as follows:

1. To ensure that services are delivered to nursing home residents, the regulatory system must focus on the needs of residents

2. Standards for nursing home care must be objective, consistent, simple, and well-defined

3. The regulatory system must maintain accurate information about the quality of services provided to residents on a regular and on-going basis

4. The enforcement system should ensure that providers, as a condition of participation in the benefits program, comply with the standards agreed to in the provider agreement. The system should have a variety of methods to encourage compliance

5. The regulatory agency should assure that nursing homes spend public monies efficiently and effectively to maximize their ability to provide quality care that meets the needs of residents

6. The system shoud ensure the availability of services to those in need without discrimination on the basis of race, sex, religion, diagnosis or method of payment

7. The regulatory system should promote development of a sufficient range and supply of services, including trained personnel, in sufficient numbers to meet residents' needs.

We reaffirm the principles contained in the document, copy enclosed.

Response to PaCS

PaCS (Patient Care and Services), the inspection process proposed by the Department of Health and Human Services on October 31, 1985, addresses one important part of this total regulatory system -- how information is gathered about the quality of services residents receive. We commend its

focus on outcomes of care and its direct involvement of residents in the inspection process. This proposal offers potential for improving the inspection process, andiits refocus on residents makes it an important step in the right direction. Yet it remains one step, which by itself, cannot provide the changes necessary to assure high quality care and services for nursing home residents.

In its current form, the PaCS system is not yet adequate for use in making legal determinations about whether or not a facility should be recertified for Medicare or Medicaid. PaCS presents a method for gathering information and screening for problems through discussion with a sample of residents on a sample of issues. It does not, in its present form, guide surveyors sufficientlv to enable them to determine where a facility is deficient or what is an appropriate plan of correction. Moreover, it does not include adequate tools for enforcement of standards of care or assurance that each individual receives appropriate and high quality care.

Before PaCS can be used for certification purposes, its forms and guidelines need to be revised and reorganized significantly to provide more guidance to surveyors on how to register deficiencies based on what thev observe. The forms should retain all the Conditions of Participation, and the elements and standards, each of which should be reviewed during each survey. Each section of the guidelines should be reworked to include a rights component and a psychosocial component. A more detailed discussion of preliminary recommendations on the PaCS materials and processes, including the resident sample, is attached.

HCFA should conduct an educational campaign to promote and support residents' participation in the survey process, through development and distribution of an explanatory brochure, and coordination with local ombudsman programs in work with residents and families.

Since PaCS is an important step in the right direction, HCFA should continue its evolution and development. Testing of PaCS instruments and training in the PaCS philosophy should continue and expand, so that HCFA and state surveyors can maintain the positive momentum towards PaCS and move close to implementation of this system. Training, particularly in communication and observation skills, should be conducted by HCFA for every surveyor.

Conclusion

As HCFA-HHS maintains its commitment to PaCS and continues development and progress on PaCS, HCFA should also begin efforts to reform the rest of the regulatory system. We support the work plan of the Acting Director of the Office of Survey and Certification (see attached) and urge the Department to progress in its efforts to build a regulatory system which truly assures high quality care and services for each nursing home resident.

NCCNHR will submit more detailed recommendations specificaly on PaCS to HHS-HCFA as soon as possible. The PaCS proposal is an ambitious one, the materials are complex and sensitive. Once again, we call upon the Department to extend the comment period by 60 days in order for the public to respond to this important proposal, particularly in light of the fact that key materials for the PaCS process have only recently become available.

We commend HCFA for initiating this important refocus of the survey process and urge the Department to approach needed reform of the entire regulatory system with a similar vigor.

Senator PRYOR. This has been a fine hearing. I do have a few questions I would like to ask. You shared an awful lot of information with this committee, and I want to thank you for that on behalf of the chairman and the members of the Aging Committee and the Senate.

But I want to share a little bit of information with you, if I might, at this time. I want to tell you about a poll that was taken in our State of Arkansas, completed only 2 weeks ago. One thousand respondents or citizens in our State were asked the following question: For what cause would you be willing to pay additional taxes? They had about 10 things: defense, help the farmers, help the schoolteachers, help small business, and on down the line.

By far and away, what the people of our State said they were willing to pay additional taxes for were for elderly programs, elderly programs. I think that probably is pretty representative and mirrors the feeling throughout this country of support for these programs.

My question, then, goes to Ms. Casper—and I imagine several on the panel could answer this. Is this money that the Federal Government is expending going to the nursing home owners primarily, or is it going for patient care? I know that is a difficult question, and I know that is a complicated issue.

I also would like to follow along with a question to you, if I might, on whether or not it is your sense that the nursing homes that operate for a profit versus nonprofit—and this question also to Mr. Thompson—whether you get fewer complaints from the nonprofits or those operating for a profit. We have not really gone into that this morning, but I wonder if either of you might touch on that?

Mr. THOMPSON. Senator Pryor, with respect to the profit and nonprofit facilities, in our State, clearly, the nonprofit facilities have higher staffing ratios because they have invested over a period of time in more staffing; we tend to have less complaints for nonprofit facilities.

With respect to where the funds go——

Senator PRYOR. That is a tough one, I know, and probably an unfair question.

Mr. THOMPSON. That is a very, very difficult question to answer. I would point out that nursing homes are doing well on Wall Street. Beverly Enterprises and others are buying nursing homes in Washington State above the appraised value. That was even after Congress passed the 1984 Deficit Budget Reduction Act that said they could not get an increase in reimbursement as a result of an ownership change.

Senator PRYOR. So are you saying that a for-profit nursing home is a good profit venture?

Mr. THOMPSON. I would say they seem to be doing very well.

Senator PRYOR. And getting better because the number of patients and residents will double in the next 20 years?

Mr. THOMPSON. Well, they are not like the corner grocer, who runs a real risk; they have got a guaranteed business.

Senator PRYOR. This is a completely different issue and I think that one of these days we ought to hold a hearing on it, because

this is something that was pretty well gone unnoticed up to this point.

Mr. Lopez.

Mr. LOPEZ. Well, the occupancy rate in Los Angeles is approximately 94 percent.

Senator PRYOR. Ninety-four percent.

Mr. LOPEZ. Right. That is 400 nursing homes. And that is part of the problem. If you find a facility, it may be 80 to 200 miles away.

Senator PRYOR. Ms. Casper touched on an issue awhile ago, and that was reimbursement to the nursing homes. Let us talk about reimbursement to the employees of a nursing home for a moment. Let us talk about that orderly, or let us talk about that nurse, or let us talk about the attendant that is there over the weekend.

Are these people adequately paid?

Ms. CASPER. No. Clearly, I believe there is a problem with reimbursement for nursing home staff, and that was part of my first point. There must be competent staff to care for the increasingly complex residents—but how do you attract and maintain competent people in this environment? You do that by paying them and recognizing their worth. And I think it is definitely an issue.

Our firm has done some studies regarding pay, and typically, nursing assistants, whom, as you have heard, render about 80 percent of the care in facilities, are typically paid at the minimum wage, and the turnover rate is extremely high.

Senator PRYOR. If I might, let me ask Ms. Doyle a question. Do you believe that in your mother's case, Ms. Doyle, that your mother's care was adversely affected because she was a Medicaid resident or patient?

Ms. DOYLE. Well, in the last nursing home she was in, I do not think it would have made any difference whether she paid or she did not pay, because most of the patients in that home were on Medicaid; because of the conditions there, paying patients were few. And that is something that I seemed to find when I was going around surveying nursing homes for my mother; the openings were always in the worst places, which means that people who intend to pay but have an emergency situation that requires finding a nursing home quickly will find that opening in a nursing home that is one of the worst.

Senator PRYOR. Ms. Doyle and Ms. Dowling, you are both, by the way, very courageous to come here today, and I think your testimony was very worthwhile; let me say that.

Let me ask both of you this question. Let us say my mother was still alive, and I was searching for a nursing home—and I get this question constantly—what should I look for in a nursing home? What should we be looking for today in trying to find a home that renders the best care?

What criteria do you use? Or, can you walk in there and just say this is a good place, or this is a bad place? Can you sense that immediately?

I wonder if you would have a comment on that.

Ms. DOWLING. We based ours on how it smelled, how it looked, if it looked clean, how the patients looked; if the patients had a lot of company, it seemed like it was better. We also asked people that we knew in Napa who had people at a rest home or a convalescent

hospital. And we checked with our large acute hospital in Napa, and they gave us names of ones that would be available. I would like to comment on one other thing, when you were talking about the Medicaid and that.

Senator PRYOR. Yes.

Ms. DOWLING. In the home that my grandmother was in, they brought in a lot of private people from like Kaiser Permanente Medical Hospital. Those patients had the best care. They would have nurses' aides in there every 15 minutes, checking on them.

Senator PRYOR. Now, why is that?

Ms. DOWLING. Because I guess it was a private—it was not somebody who was on Medicare or Medicaid. That is how I feel.

Senator PRYOR. They were paying individually, then, rather than from the Government.

Ms. DOWLING. Right.

Senator PRYOR. And so they got a higher quality of care; is that what you are saying?

Ms. DOWLING. Right.

Senator PRYOR. Ms. Doyle.

Ms. DOYLE. This was my experience as well, in the early nursing home in Florida. When my mother was a paying patient, her care was good. As soon as she went on Medicaid, she was moved to another section of the nursing home, and her care level dropped. The nursing staff was not as capable as the nursing staff on the other side, and she just received a poorer level of care.

Senator PRYOR. Were either of you ever aware of State or Federal inspectors in the homes while you were there, helping and assisting your mother and your grandmother? Were you aware of Federal inspectors, and if so, did you go to them and register a complaint? Or, you never saw an inspection while you were there——

Ms. DOYLE. I realized after I came in contact with other people in the investigation of her last nursing home that some of the people I occasionally saw were inspectors. And had I known that, I would have had more courage to speak out and would have talked to them. But I had no way of knowing who they were when I saw them.

Senator PRYOR. I see.

Did you find that the families of other patients in the home had a fear of complaining?

Ms. DOYLE. Definitely.

Ms. DOWLING. Yes.

Senator PRYOR. By the way, Ms. Casper, do you find this—and I also would ask Toby Edelman this—are you finding that there is an increasing amount of fear in the nursing homes for people who complain?

Ms. CASPER. Increasing fear of reprisal for complaining?

Senator PRYOR. Yes.

Ms. CASPER. I cannot personally attest to that, but I do know that the new PACS process has made strides in this regard in that a very large part of PACS is a confidential resident interview. And if the interviews are accomplished the way we would hope that they will be, they will get at that issue.

Senator PRYOR. I see.

Toby.

Ms. EDELMAN. It is inevitable that there is tremendous fear on the part of families and residents. That is one reason why it is very important that the Federal and State systems be aggressive and active, because the residents and families are, in many instances, unable to speak up, or afraid of speaking up on their own behalf.

The New York attorney general just filed a case against a nursing home for using a private pay duration of stay contract, which requires the family to pay privately for 18 months, instead of accepting the Medicaid rate. In the press release announcing that lawsuit, the attorney general says, "We are unable to get too many complaints from people because they are afraid, but we understand that this happens a lot."

Senator PRYOR. I see.

Mr. Thompson.

Mr. THOMPSON. Yes, there is another form of fear of reciprocity, and that is the staff who work in the nursing homes.

Last week, I met with five nursing assistants from the State of Washington all afternoon, and when they first came to meet with me, they just wanted me to know their first names. When they left, they felt a little better. Reciprocity was one of their key concerns.

Senator PRYOR. In other words, the staff was afraid to tell what was going on in the particular home for fear of losing their jobs or whatever.

Mr. THOMPSON. Yes. There should be a mandatory statute on anonymity and confidentiality in those cases, and provision for criminal prosecution when reciprocity, takes place.

Mr. LOPEZ. Even with our so-called guarantee of confidentiality, of the last 5-year average 1,500 complaints, I would say fully one-third were anonymous, and they went to great lengths to conceal exactly who they are, to protect that confidentiality, because of the fear of retaliation.

Senator PRYOR. We have a great deal of trouble today with our Department of Defense. They do not like whistleblowers. And this is true, I guess, in the nursing home industry as well.

I have a question for you, Mr. Thompson. You brought some new and very fresh information in your statement today that the committee was not aware of. What has been your experience with the implementation of the new long-term case survey process? What has been your actual experience with that?

Mr. THOMPSON. First of all, Washington State residents have been benefiting from an outcome-oriented survey process for 5 years under a Federal waiver requested by the State of Washington.

If your question gets at what has my experience been in trying to implement PACS and the new Federal long-term care survey process, unfortunately, I regret to report today it has not been a very good one.

We were asked to survey only homes that had no problems. We were told to implement the new system on January 1 with no training. Then we were told we were going to all get training materials. We did not get them; we received only one copy.

Senator PRYOR. Who is responsible for that?

Mr. THOMPSON. The Health Care Financing Administration.

Surveyors in Washington State were trained approximately 30 days ago. The implementation has been delayed and delayed again, and I have a gap of time between training and implementation of the new process. This is very undesirable.

And then, I am more discouraged to report today—and I have been a supporter of moving to an outcome-oriented survey process, and particularly in those States that do not have an outcome-oriented process—that looks at actual patient care, because we need to make that first step forward, and I guess that is where I agree with Dr. Roper.

On May 15, I received the new survey forms. I had them evaluated by nine surveyors and two managers. I left a copy with your staff today.[20] Survey staff are tremendously upset; in fact, they asked me to consider getting a court injunction to stop the use of this new form. Our surveyors were excited about trying the new process, until they saw the new form.

Senator PRYOR. How lengthy and complicated is the new form?

Mr. THOMPSON. This yellow document is the form, and this is the analysis of it. It reduces services for ICF patients; it changes requirements; it confuses their tag numbers. I encourage you to have your staff look at it carefully.

When surveyors are concerned, I am concerned.

Ms. CASPER. May I make a followup comment, Senator?

Senator PRYOR. Yes.

Ms. CASPER. We have lived and breathed PACS since 1984. We developed the original training, the draft that HCFA was going to be using for training its surveyors. But HCFA is utilizing a "train the trainers" concept that was completed in March. Essentially, 300 of our Nation's 2,000 long-term care surveyors will be trained by this trickle-down theory.

And what is happening is that we have contracts now with 19 States to train provider—providers, not regulators—in the new process. The regulators are just now coming to grips with the fact that they indeed are not ready or prepared to deal with this new process. Within the last 6 weeks, we have gotten contracts from two State licensure agencies who say, "Help. You developed the core of the training for PACS. Please come and help us figure out how to implement it."

In addition, when we are presenting to providers, we always encourage that the State licensure agency be there, because it is critical that they discuss how State licensure and Federal certification is going to interface. Most of the States have declined simply because they say, "We have absolutely no idea how on earth we are going to implement this new program." And it is a real concern.

Senator PRYOR. Well, you have both given very good testimony on that point, and something for this committee to consider.

Mr. Lopez, I got the idea from your testimony that you had established sort of a team of crack troops, or maybe an "A team", or "SWAT team", whatever you want to call it.

Mr. LOPEZ. Yes, we call it the enforcement surveillance.

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[20] "Please see volume II, appendix 6, p. 406, letter to HCFA dated June 28, 1985."

Senator PRYOR. Let us say we tried that on the Federal level—who would we hear from in opposition to that?

Mr. LOPEZ. Well, you can rest assured that you would hear from the National Association of Homes—in California, the California Association of Health Facilities and their national offices—anything that goes to a heavier enforcement and their national counterpart is going to come back and say, "Look, you are violating a law"——

Senator PRYOR. Did they actually oppose your doing this?

Mr. LOPEZ. Absolutely. If we did not have a certain sense of autonomy in being a county, and a large county politically, we would probably have been deep-sixed about 4 or 5 years ago, in terms of end runs that were made directly to our State offices. Those end runs continue on the administrative side—State licensure, anything else that goes with that.

But we have fortunately been able to put together a political coalition of all parties with the coroner, the public guardian, the district attorney, the city attorneys and health facilities division itself, to withstand any kind of real pressure.

In fact, I was looking at our statistics before I came, and we have prosecuted at least 46 cases in the last 5 years, and we do not consider that a lot. But when you compare that to other States and other regions, who have either one or zero, it makes us look as if we are out there, the "A-team," as it were. We think that that is just part of the total balance, and that we have not gone completely overboard in any one direction or the other.

Senator PRYOR. We have a Humane Society that looks after animals, and it looks like we could have something similar to look after humans.

Mr. LOPEZ. Well, half the evidence disappears if you do not coordinate with your medical examiner. We have for the last 5 years, statistics on each and every death in every nursing home and hospital in the county of Los Angeles. We have routine meetings with our counterparts. We have checkpoints at the emergency rooms for this dumping in either direction.

Unless you do that, even if you thought there was a case, you will not have the evidence—things that we discovered 4 or 5 years ago, or even longer, I think. I keep using 5 years, but I am sure it is longer than that.

Senator PRYOR. The videotapes that you brought to the committee today were most effective. Now, what has been the impact of this type of evidence-gathering that you have involved yourselves in?

Mr. LOPEZ. Well, even before we issued any kind of a deficiency, we heard about it from our State capitol that there was a bill introduced—there are two bills, one of which was killed, and the other one that is somewhere wending its way in terms of attempting to eliminate this as evidence. We think we can overcome that. But we had not even issued the deficiency, and there was already the opposition.

Senator PRYOR. Well, was it the nursing home industry that opposed this?

Mr. LOPEZ. Yes, it is the industry. In the State of California——