S. HRG. 106–430

CONSUMERS ASSESS THE NURSING HOME INITIATIVE

FORUM

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

WASHINGTON, DC

SEPTEMBER 23, 1999

Serial No. 106–15

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

62–416 WASHINGTON : 2000

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402

ISBN 0-16-060444-3

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CONSUMERS ASSESS THE NURSING HOME INITIATIVE

THURSDAY, SEPTEMBER 23, 1999

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

The committee met, pursuant to notice, at 10 a.m., in room SD–608, Dirksen Senate Office Building, Hon. Chuck Grassley, (chairman of the committee) presiding.

Present: Senator Grassley.

OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN

Chairman GRASSLEY. If it is OK with everybody, I would like to get started, even though it is probably a very disorganized start because we were hoping to have Senator Breaux here at the same time I was here. We would take a couple of minutes of your time and the panel's time to open up. So I raced over here—in between the first vote and the second vote hasn't started yet—mostly to thank you and also to apologize that something this important had to be done under these circumstances, that we are in and out.

So the most important thing for me to do is to thank everybody who is participating, most importantly. And it is never easy to hear the painful stories such as those that witnesses may be telling us about today.

Anyway, what we are hoping for today is to bring out of this particular forum an assessment of how the follow up is going. The follow-up to what we talked about at our hearing last summer and what we talked about in a follow-up hearing that we had this spring. At that hearing, I announced that I wanted to hear from the people that were involved in the work and particularly advocates for older persons in nursing homes to get their point of view of how they work.

So that is why we have this forum assembled, as a follow up on that event. Obviously Dr. Scanlon, who has been involved in all of the work of the General Accounting Office through 6 or 8 months prior to our hearing last summer, in that hearing, and in follow-up things we have asked him to do, is a very appropriate person to be able to hear and to moderate this panel. So I thank Dr. Scanlon not only for his expertise in this area, for his cooperation with us, and for taking time for panels like this as further follow up, and also an opportunity for him—I am sure he feels—to get points of view outside of the professionals within his own department who do work for and with him.

The one thing that I would want to make clear is that there might be, obviously from both Congress as well as advocates, some criticism about the regulatory process and the enforcement process. But for everybody's benefit and from only my perception, what I want to say about HCFA is that wherever they are on enforcement in everybody's minds, I do have to say that we have, since the hearing last summer—I mean in the summer of 1998—we have had HCFA giving us updates and listening to our response. There have been avenues of communication that have been very helpful, and I think it gives us an opportunity to have that dialog that is so important, even if maybe the particular atmosphere of enforcement may not be what everybody likes, but at least we see progress being made and the willingness and the heart in the right place.

So with that in mind, I am going to turn it over to Dr. Scanlon, and also then hopefully Senator Breaux will come, as the ranking minority member, with a short opening statement as well, but I don't want you to wait until that happens. I think he can break in at that particular point.

Thank you very much.

Dr. SCANLON. Thanks, Senator Grassley and Senator Breaux and the members of the committee, for all the work that you have done in terms of raising the awareness and consciousness of this issue. In terms of the work that GAO has been doing we feel that there have been very few things that we have ever engaged in that are more important because this involves a population of individuals that are extremely vulnerable and needy. Adequate protection of those individuals is something that we can certainly relate to and endorse.

We have been very disturbed by the findings that we have encountered. We recognize that there are too many instances of poor care and abuse. We are gratified though by the response that has occurred in terms of HCFA having both responded positively to our suggestions and as well as putting forth their own ideas such as the set of nursing home initiatives that we are going to talk about today.

We have also been heartened by reports of things happening in States. We have met on a couple of occasions with the committee of the Maryland General Assembly which has been very concerned about nursing home quality and is interested in pursuing actions to improve nursing home care in Maryland.

While these are the positive sides, we recognize very much more needs to be done. HCFA's ideas are in some respects skeletons that need to be filled out in terms of the details and also need to be implemented across the board, across the country. Even after they are fully implemented, we have to be very sensitive to the issue of maintaining them. If we do not maintain them in terms of being faithful to the original ideas and the original details, we are going to see deterioration, and we would potentially return to an intolerable situation.

We also, we need to learn a lot more about how to improve nursing home care. We don't feel that in the process that we have engaged in to date that we have discovered all the answers. Part of that process of finding more answers. Learning how to fine tune these answers is greatly facilitated by events like today's where we

can hear information from people that are much closer to nursing homes, to the oversight process, and who can give us insights that will guide us in the future.

We need to find ways to be able to monitor our progress in terms of correcting the problems so that we can understand which of these initiatives are working well so that we can target resources for the future. We are never going to be able to oversee every home every day. So, we need to be able to target the resources to where the problems are. That way we will develop an effective system from this process.

I would like to introduce our panelists. While the panels were listed in the agenda as first presenting positive perspectives and then discussing continuing concerns, there is some of both throughout all the testimony. So we will have the panel discussions and then open this up to discussion with questions and answers.

Let me introduce everyone now. The first person on my right is Mr. Raymond Suarez from Crisfield, MD. He lives there with his wife. He is recently retired from the Baltimore County Public Schools after a 30-year career as a secondary social science teacher and a mentor for new teachers. From 1992 to 1997, he served as the president of the Teachers Association of Baltimore County. He is going to tell us about a complaint that he made to the State of Maryland about care that his father received in a Maryland nursing home, and how, that after prompt investigation of the complaint, the facility was cited for a G-level deficiency. According to State officials, had Mr. Suarez not complained, the State would have never been able to find out about this problem.

Then we are going to hear from Debi Meyers who serves as the interim long-term care ombudsman with the Iowa Department of Elder Affairs. She has worked in State Government for 10 years, most recently as a Medicaid policy specialist for nursing facility policy. She also served as a volunteer conservator and guardian through the county attorney's office for persons in nursing facilities since 1989, which has given her some extensive first-hand experience with understanding what families go through when they have a loved one in a facility.

Then we will hear from Mr. Mark Miller. Mr. Miller has been the Virginia State long-term care ombudsman since April 1992. In 1996, he served as the interim executive director of the Virginia Association of Area Agencies on Aging. He has also worked in the ombudsman program in various capacities since 1984, and over the past several years, has worked to develop a coalition of elder rights services to promote more effective advocacy assistance to older long-term care consumers. They hope that they can provide one central place where people can call to get information and assistance about long-term care, insurance, and public benefits, and as well as to report elder abuse and obtain legal assistance.

Finally, on this side of the room, we will hear from Toby Edelman. Toby has been the staff attorney with the National Senior Citizens Law center in Washington, DC., since 1977. She specializes in nursing home issues and recently has been chosen to represent that association in litigation surrounding the new use of civil monetary penalties. She was the lead attorney in 1990 representing plaintiffs challenging California's refusal to implement

Federal nursing home reform laws, which is an issue that she has fought extensively in five other States as well. She is also a member of the board of directors of the National Citizen's Coalition for Nursing Home Reform which advocates for improved quality of care and quality of life for nursing home residents. She will speak on the progress of current initiatives, focusing on the civil monetary "per instance" penalties as well as the other new rules that have improved the enforcement of nursing home laws.

On my left is Janet Clayton who is here from Missouri. When her mother died 5 years ago, Ms. Clayton became the guardian and caretaker for her father who suffers from Parkinson's disease. She lives in Neosho, MO, near the nursing home where her father resides, and she visits him daily, sometimes twice a day. She finds courage and motivation to try and help others in nursing homes from her father's example and the pain that he has suffered. She will discuss his care and the results of the investigation conducted following an injury he recently received.

Next is Mr. Kimm Korber. Mr. Korber is here today from the State of West Virginia, but until recently, he resided in the State of Pennsylvania. His mother, Bettie Jane Korber, suffered a debilitating stroke in March 1990 and has been a nursing home resident since April 1990. During the course of Ms. Korber's more than 9 years at Beverly Health Care in Murrysville, PA, Mr. Korber has dealt with many issues concerning the quality and consistency of her care, the quality of life, and communications with facility management. He is going to speak today about what has happened with his mother over the past 18 months, and about his experiences attempting to address and resolve concerns with Beverly Enterprises. He will discuss a complaint he filed with the State which, as a result of a survey which was conducted in response to the complaint, and which led to the citation of deficiencies.

Next will be Deanne Lenhart who is from Lawrence, KS. She is the executive director of the Kansas Advocates for Better Care which is an independent Statewide nonprofit organization that advocates for quality long-term care for adult nursing home residents. It was founded in 1975, and it has more than 500 members. She is going to speak about the need to improve HCFA's management information systems. She will also discuss an example of how the complaint process can be very cumbersome in its current form and the value of the Internet to communicate to consumers. She will also discuss the need for more funding at the State level to initiate the Federal initiatives.

Finally, on the panel here today, we will hear from Elma Holder. Elma is the founder and former executive director of the National Citizens Coalition for Nursing Home Reform. She helped develop that organization as an outgrowth of her work with Ralph Nader's Retired Professional Action Group and National Gray Panthers in 1975. The coalition advocates for improved quality of care and quality of life, as I noted before, for nursing home residents. Since serving as the executive director for 20 years from 1975 to 1995, she has continued her work in analyzing program and policy issues related to nursing home care.

Before we hear from the panelists that are here today, we are going to hear a video presentation from Mr. Nelson Baugh. Mr.

Baugh is a resident of the BJC Nursing Home in Commerce, GA and has lived there for 10 years. He became paralyzed from the waist down when he was thrown from a car during an accident in 1969 at the age of 22. He lived with his parents until his mother died in 1985, and then he lived with his sister and her family for 4½ years. He then decided move into a nursing home, and he chose the BJC home because it was close to his hometown.

He is going to tell us about his complaints over the years and his delight that a staggered survey confirmed his and other residents' complaints about staffing levels, cleanliness, and other concerns. The facility that he lives in was cited by State surveyors for 25 deficiencies, and immediate jeopardy was declared. A civil monetary penalty of $3,250 per day was imposed.

Let me turn now to the format for today's forum. We are going to hear the presentation on video from Mr. Baugh, and then we are going to hear from each of the panelists that I have introduced. Because we have so much information, we have asked each of the panelists to limit their remarks to 5 minutes, and we are going to use the lights as gentle reminders. And think of it this way: Any time that you save will be more time for the rich discussion that we are going to have after the panel presentation.

In order to facilitate that discussion, we are going to pass out cards so that you can write questions. We will group them in terms of similar topics and hopefully answer the maximum number possible in the time that we have available.

So now let us turn to the video from Mr. Baugh.

STATEMENT OF NELSON BAUGH, RESIDENT, BJC NURSING HOME, COMMERCE, GA (VIA VIDEOTAPE)

Mr. BAUGH. My name is Nelson Baugh. I am a resident of BJC Nursing Home in Commerce, GA. At 22 years of age, I was in a car wreck that threw me out and broke my neck and paralyzed me. I lived with my mother and dad up to 1985 when my mother passed away, and I decided to go into a nursing home.

I have been in a nursing home for going on 10 years now, and this is a very good nursing home. I like a lot of the people in here, and I know a lot of the people because my hometown is a few miles from here. I love the people in here, and I can speak up for them. I love taking care of them, because I can speak up for them, because I really do care about them. When I see them hurt, I hurt. So I want to see them taken care of like I do myself.

I have been asked the question about State and how they do. In the past over the years, I have watched State. They come in. They don't do a thorough job like they should. It seems like there is some—every time they come, they know when they are coming, when they come in every year at the same time.

And it is like when you have complaints here, you go to the nurses, the administrators, and it is like they push you aside, and they just don't listen all that much. It is like the State, when you have got a complaint, you call and they come and then you get pushed aside.

But this year, in July 1999, was a little bit different. They came in on a weekend which was very rare, and they counted the people that was on, and anyway, they came in on a Sunday morning, and

they caught them red-handed. They caught them short-staffed, the nursing home smelling, the residents wasn't taken care of. There was food problems. There was noise problems, and the State come down on them, and they come down on them hard, and this is what me and other residents have wanted for a long time.

And this is—I wish the State would keep this up, and I have been watching them since July. They have been coming in and making spot checks, which this is another good thing. When they come in and make spot checks, the nursing home don't know when they are coming or when they are about to come, and it keeps the short staff down, and they are trying their best to keep it up and do everything safe, and I wish Federal would stay on State to stay on the nursing homes to make sure everything is done right.

And I would like the State to come in with a white glove on and stay on the nursing homes to make sure everything is done right, and I would like the State to come in with a white glove on and go out and that white glove is clean and that white glove will stay on in the nursing home until the next survey or to the next spot check.

I wish all of those that are listening to this video would take it to heart, because we are human beings just like you all are, but a little bit different. We need taken care of. You all can do things we can't. We need help.

So I hope the good lord keeps us in everybody's heart about this, because it is a very serious thing. There are so many nursing homes throughout the United States, and there are so many people hurting, and we need your help, because when we come into nursing homes and they agree to take care of us, it is priced when we come in. And we can't help it because there are funds that they are cut, because we need are your help, and we would like to be taken care of right.

So please take this to heart, and I thank you for listening, and God bless each and every one of you. Thank you.

[The prepared statement of Nelson Baugh follows:]

September 10, 1999

My name is Nelson Baugh. I am 52 years old and a resident of BJC Nursing Home in Commerce, Georgia. I was in a car accident in November of 1969, resulting in a broken neck and paralysis from the waist down. I was in rehab at the Shepherd's Spinal Clinic in Atlanta, Georgia for six months, then lived with my parents in Jackson County, Georgia until my mother's death in 1985. I moved to Douglas, Georgia to live with my sister and her family, and later moved to a nursing home in Douglas. I was transferred to BJC in my home county of Jackson about 10 years ago. Despite my disability, I am alert and in my right mind. God has given me the ability to paint, which I do regularly. I have sold some of my paintings and participated in various exhibits and art shows. I am able to get around in a motorized wheelchair. I am familiar with many of the residents in the nursing home, most of whom are elderly and cannot speak for themselves, being totally dependent. I advocate on their behalf whenever I can, because when I see them hurting it hurts me too.

In the time I have resided here, I don't believe the nursing home has always done their job in providing quality care for the residents. Although I, along with other residents, have complained to the nursing staff and also to the administrator, and have even contacted the state Office of Regulatory Services (ORS), the problems not only remained but got worse. The problems I'm speaking of include shortage of staff, bad odors, verbal abuse, problems with the food, cleanliness, lack of privacy, and failing to contact the doctor when the circumstances called for it. When the ORS would come for their annual inspection, the nursing home would be ready for them because it was always every 12 months, and always on a week day during business hours. If they did find deficiencies, they would give them time to correct before imposing penalties and once they left, the problems remained.

The survey conducted in July of 1999 was different. It was the most thorough survey that I have ever seen, and more deficiencies were found than ever before. The ORS came in very early on a Sunday morning and saw the situation clearly for the first time. The shortage of staff was very evident and the lack of care to the residents could not be denied. As I understand it, they imposed immediate penalties and have been conducting spot checks periodically, in order to insure the nursing home comes into and stays in compliance. The result has been much improvement in the care of the residents, and has greatly increased their morale.

I think the federal government should stay on the states and the states on the nursing homes. They should come into the facilities with a white glove and leave with that glove white. It should be mandated by the government that the nursing homes keep enough trained staff to adequately care for the residents. This past survey is proof that the increased enforcement and monitoring of the nursing homes DOES result in better care. The nursing homes admit residents and take what funds the resident has each month with the understanding of the resident that he'll get the proper care. Please help do what you can to see that their rights are protected, and they are given the care to which each individual is entitled.

Thank you for given me this opportunity to help to advocate for residents in nursing homes and God bless each of you.

Sincerely,
Nelson Baugh

Nelson Baugh

Dr. SCANLON. Thank you. Mr. Suarez.

STATEMENT OF RAYMOND SUAREZ, FAMILY MEMBER OF A NURSING HOME RESIDENT, BALTIMORE, MD

Mr. SUAREZ. Thank you.

My father, Raymond Suarez, was a resident of Salisbury Center Genesis Elder Care Nursing Home in Salisbury, MD from July 6, 1998 until his death July 31, 1999. The social worker recommended Genesis Elder Care to me because it had a dedicated and a secure Alzheimers unit.

It was obvious to me from the beginning that the staffing and the care there was not going to be satisfactory, so I hired a caregiver to drive 60 miles round trip each day, between 5 and 7 days a week, sometimes with my mother accompanying her to make sure that he got one large meal a day—because his weight had fallen off—that he was kept clean, that the bed was not soaked with urine, there were not sores, etc.

During the last year, I conservatively made maybe 100—maybe 200, thinking about it—long distance phone calls from my home in Baltimore whenever I got the complaints from the caregiver and my mother. Sometimes it was three calls a day for three shifts. I had to follow up on delayed medication orders and correct food preparation and broken wheelchairs. Generally speaking, it was my mother, the caregiver, or myself who had to make the complaints about the fevers, the wet beds, the clothing, and also the one who had to demand that a nurse practitioner or staff doctor see my father.

June 7, 1999, I was called by the nurse practitioner who said my father was dehydrated and had a urinary tract infection. She recommended he go to the hospital. I concurred, but I was upset that how could he become dehydrated. She bravely said that this should not have happened. Three days later, I called the ombudsperson for the Department of Aging in Salisbury, MD. She recommended I call the licensing bureau. I left a phone message, was called back later that day by a staff person who took my information and my concern and said there would be an investigation forthcoming.

August 18, 1999, I received a phone call from an onsite investigation team saying they were investigating my concerns. They had already found some problems with my father's dehydration and asked me if I had more concerns. I talked about the ensuing 3 weeks—which my father has hospitalized again and brought back into the nursing home essentially to live out his last days—and my concerns there about inability to get information from doctors and my concern about his pain medication protocol being followed.

About 10 days later, I was called back, and they said they indeed had investigated that part and found that my father's pain medication protocol had not been followed during his last days, and, unfortunately, he was not out of pain during that time. Ultimately, there has been a final report which has cited the nursing home and recommended fines be levied and that certain program deficiencies be corrected.

I have to admit when I made the phone call, I was just skeptical. I knew, going in, what nursing home problems existed, and like all of us, have some skepticism about bureaucracy, despite spending

my life in a large one. I understood from the discussions later, had I not been very specific in my comments that they could not have carried through such a thorough investigation.

I have been very heartened by this. I have talked to lots of other people about it and feel that there is a chance that future residents of nursing homes such as this and others, the residents will receive a better level of care.

[The prepared statement of Raymond Suarez follows:]

CONSUMERS ASSESS THE NURSING HOME INITIATIVE
TESTIMONY OF RAYMOND E. SUAREZ
BEFORE THE U.S. SENATE SPECIAL COMMITTEE ON AGING
September 23, 1999

My father, Raymond Suarez, was a resident of the Genesis Elder Care nursing home in Salisbury, Maryland, from July 6, 1998 until his death on July 31, 1999. Salisbury Center, Genesis Elder Care was chosen because it has a dedicated and secure Alzheimer's unit. Due to irregular and what I perceived as sometimes neglectful care, I was forced to pay a caregiver to drive 60 miles round-trip five or six days a week to ensure that my father received at least one full meal per day and that he would be checked for sores, wet bedding, and proper hygiene. I made perhaps 75 to 100 long distance calls to make sure that proper care was given, following up concerns that ranged from delayed medication orders, incorrect food preparation, and broken wheelchairs. It seemed to me that staff shortages and turnover resulted in insufficient attention and care for my father. Frequently, the caregiver, my mother or I became the ones who discovered the fevers, the wet beds, the clothing caked with food, the sores, and generally the ones who had to demand that a nurse practitioner or a staff doctor see my father.

In late June of this year, my father was hospitalized, suffering from a urinary tract infection and dehydration. I was extremely upset about the dehydration and asked a nurse practitioner at the nursing home how that could have happened. She very bravely said that it should not have.

The following week I phoned the ombudsman for the local office on aging in Salisbury; she suggested that I call the Maryland state agency in charge of licensing and regulation of nursing homes and file a complaint. I called the agency, left a voice mail message and received a call from a representative the same day. She took note of my complaint and told me that someone would respond and pull records. On August 18, I received a call from an on-site investigator, who was directing a team of investigators. He informed me that they were on the job and he elicited additional concerns that had arisen since my initial complaint. I reported the failure to provide a working jerry chair, the difficulty in contacting staff physicians to understand the extent of my father's condition, and the need for me to monitor my father's pain management protocol during his last days. The investigator indicated that the team had found significant problems and that he would call me when the report was completed. The investigator called me ten days later and informed me that the investigation revealed additional problems with my father's pain management and gave me a number to call to receive a written copy of the report.

I understand that the investigation and report resulted in a fine and requirements that the nursing home effect specific improvements during a specified time.

Quite frankly, I was surprised and pleased that anything came from my telephone call, let alone a thorough investigation with the clear hope that future residents of Genesis Elder Care receive better treatment. I learned from an official in the state office regulating nursing homes that my specific complaint was integral to the investigation, pointing out problems that a standard audit would not have revealed. It is important to me and to any one who has a family member in the care of a nursing home to know that there is recourse and that we can contribute to improvements in the system.

Thank you.

Dr. SCANLON. Thank you very much, Mr. Suarez. Ms. Meyers.

STATEMENT OF DEBI MEYERS, INTERIM STATE LONG-TERM CARE OMBUDSMAN, DES MOINES, IA

Ms. MEYERS. Good morning. My name is Debi Meyers. I am the interim long-term care ombudsman in Iowa. I am here today, representing the Resident Advocate Committee Program. It is a unique program comprised of 3,500 volunteers who are committed to safeguarding and improving the lives of our nursing facility residents.

Every long-term care facility in Iowa is required to have a Resident Advocate Committee comprised of volunteers from the community. The program is under the direction of the State Long-term Care Ombudsman Partnership with the Area Agencies on Aging.

Resident advocates are responsible for getting to know each resident assigned to them so that the resident feels comfortable talking to the advocate about life at the facility and any concerns they may have. These volunteers are expected to visit the facility frequently at different times of day and different days of the week. Because they are in that facility on an ongoing basis, they are the first line of our State's advocacy efforts. They are the ones who are most keenly aware of how an individual facility operates and can most immediately intervene on the residents' behalf.

We have not seen much impact in Iowa from the nursing home initiatives. Our survey agency began off-hour surveys in February and incorporated quality indicators in August. Guidance was recently issued to facilities to define under what circumstances "per instance" CMPs would be imposed. The investigation of abuse allegations within 10 days requires additional funding which would not be available until July of next year at the soonest.

While we are waiting and hoping for further enforcement changes to unfold, there are some components of the initiative that are affording us an unanticipated opportunity to enhance the advocacy work of our volunteers. One of those areas relates to the strengthening of the tie between local advocacy and State and Federal efforts.

One of the dilemmas in managing a volunteer program of this size is the difficulty in instilling a sense of connection between the individual volunteers and broader public policy initiatives. Volunteers can easily feel detached from what is happening in Washington or in the State capitol because it is not a daily reality to them.

The new Federal initiative related to nutrition and hydration provides us a way to link directly to the work of the local volunteers. As part of our ongoing training, we are creating training modules around hydration and nutrition that will help volunteers understand the critical importance of these two issues and how their work can dovetail with that of the State survey agencies.

Advocates will learn in more detail what to look for when they monitor dining in the facility, including such things as assistive devices, atmosphere in the dining room, appearance of the food, and positioning. Our intent is also to include best practices so volunteers will have ideas they can discuss with administration and to help set higher performance standards. The local advocates become the eyes and the ears to ensure that facility activities related to hy-

dration and nutrition are not forgotten once the survey team leaves.

We are also planning the same type of training on abuse early next year. By translating Federal policy direction into a local reality, we believe we are able to help our advocates see that they are an important part of the broader network of partners who share a similar vision. But while our efforts will continue at the local and facility level, it is our hope that the commitment to system reforms will continue at the Federal level.

The dedication of Resident Advocate Committee volunteers is impressive. Unlike those of us who choose careers in long-term care, these are men and women who use their personal time and personal resources, without compensation, to do what they can to improve the lives of nursing facility residents.

While Iowa may have a larger number of trained volunteers than many States, there are volunteers in facilities all across the country who share the same fervent hope for an improved quality of life for those in facilities. They are looking to Federal and State policymakers to be equally committed to that same goal.

Knowing that their advocacy is driven by genuine compassion, it is disheartening to lose good volunteers who feel that the regulatory system has let them down and let the residents down. When complaints are not substantiated, or the survey process fails to identify problems that the residents see every day, or a substandard facility again sidesteps a fine, it is difficult for even the most passionate advocate to not become disenchanted. We must continue to reassess the survey process to make it a better measure of the quality of care and quality of life in our facilities.

The nursing home initiatives are a welcome start at improving our long-term care system, but they are only a start. Failure to fully implement the initiatives and continue sharpening our regulatory system would be a breach of trust to our residents, their families, and thousands of committed volunteers.

Thank you.

[The prepared statement of Debi Meyers follows:]

Testimony of
Debi Meyers, Interim State Long Term Care Ombudsman
Iowa Department of Elder Affairs

My name is Debi Meyers, and I am the Interim State Long Term Care Ombudsman in Iowa. I am here today representing the Iowa Resident Advocate Committee Program -- a unique program of 3,500 volunteers who are committed to safeguarding and improving the lives of our nursing facility residents. Every long term care facility in Iowa is required to have a Resident Advocate Committee comprised of volunteers from the community. The program is under the direction of the State Long Term Care Ombudsman in partnership with the Area Agencies on Aging.

Resident advocates are responsible for getting to know each resident assigned to them so that residents feel comfortable talking to the advocate about life at the facility and any concerns they may have. These volunteers are expected to visit the facility frequently at different times of the day and different days of the week. Because they are in their facility on an on-going basis, they are the first line of the state's advocacy efforts. They are the ones who are most keenly aware of how an individual facility operates, and can most immediately intervene on a resident's behalf.

We have not yet seen much impact in Iowa from the Nursing Home Initiatives. Our survey agency began off-hour surveys in February, and incorporated Quality Indicators in August. Guidance was recently issued to facilities to define under what circumstances per instance CMPs would be imposed. The investigation of abuse allegations within 10-days requires additional funding which would not be available until July of next year at the earliest.

While we are waiting for further enforcement changes to unfold, there are some components of the Initiative that are affording us an unanticipated opportunity to enhance the advocacy work of our volunteers. One of these areas relates to strengthening the tie between local advocacy, and state and federal efforts. A dilemma in managing a volunteer program of this size is the difficulty in instilling a sense of connection between the individual volunteers and broader public policy initiatives. Volunteers can easily feel detached from what's happening in Washington or in the state capitol because it is not a daily reality for them.

The new federal initiative related to nutrition and hydration provides us a way to link directly to the work of the local volunteers. As part of our on-going volunteers training, we are creating training modules around hydration and nutrition that will help volunteers understand the critical importance of these two issues and how their work can dovetail with that of the state survey agency. The advocates will learn in more detail what to look for when they monitor dining at their facility including such things as use of assistive devices, atmosphere in the dining room, appearance of the food, positioning, etc. Our intent is to also include Best Practices so volunteers will have ideas they can discuss with administrative staff at their facility, and to help set higher performance standards.

The local advocates become the "eyes and ears" to ensure that facility activities related to nutrition and hydration are not forgotten once the survey team leaves. We are also planning the same type of training on abuse early next year. By translating federal policy direction into a local reality for our advocate, we believe we are able to help them see that they are an important part of the broader network of partners who share a similar vision.

But while our efforts will continue at the individual facility level, it is our hope that the commitment to system reforms will continue at the federal level. The dedication of Resident Advocate Committee volunteers is impressive. Unlike those who chose careers in long term care, these are men and women who use their personal time and resources, without compensation, to do what they can to improve the lives of nursing facility residents. While Iowa may have a larger number of trained volunteers than many states, there are volunteers in facilities all across the country who share the same fervent hope for an improved quality of life for those in facilities, and who are looking to federal and state policy makers to be equally committed to the same goal.

Knowing that their advocacy is driven by genuine compassion, it is disheartening to lose good volunteers who feel the regulatory system has let them down and let the residents down.. When complaints are not substantiated or the survey process fails to identify problems that residents see every day, or a substandard facility again side-steps a fine, it is difficult for even the most passionate advocate to not become disenchanted. We must continue to reassess the survey process it make it a better measure of the quality of care and quality of life in our facilities.

The Nursing Home Initiatives are a welcomed start at improving our long term care system, but they are only a start. Failure to fully implement the initiatives and continue sharpening our regulatory system would be a breach of trust to our residents, their families, and also thousands of committed volunteers. Thank you.

Dr. SCANLON. Thank you very much. Mr. Miller.

STATEMENT OF MARK MILLER, STATE LONG-TERM CARE OMBUDSMAN PROGRAM, RICHMOND, VA

Mr. MILLER. Thank you. Good morning.

My name is Mark Miller. I am the State long-term care ombudsman for the Commonwealth of Virginia. Today I am speaking on behalf of the National Association of the State Long-term Care Ombudsman Programs, or NASOP, concerning HCFA's initiatives.

We certainly applaud this committee's efforts and interest in benchmarking States' progress in implementing these initiatives to improve care, including the national campaigns, to reduce the incidents of malnutrition, dehydration, pressure sores, and resident abuse. NASOP supports the Federal HCFA initiatives to improve quality of care, and while we recognize that progress is being made, much more needs to be done.

At this point, I think it's a fair statement to say that the implementation and the measurable impact of these initiatives is uneven both within and across States and is yet to be fully recognized. Surveys continue to be too predictable, and quality of care problems remain uncorrected for prolonged periods of time. State survey agencies with limited resources and those with unionized surveyors are experiencing difficulties fully implementing all the HCFA requirements to stagger surveys, conduct timely revisits, and investigate serious complains within a reasonable timeframe.

Enhanced monitoring of chronically non-compliant facilities is taking place but is also diverting time from other survey agency responsibilities. The Abuse Awareness Campaign has experienced somewhat of a slow start. Ombudsmen in each of the 10 HCFA regions have volunteered to assist with that campaign, but because of poor quality printing, educational posters had to be recalled.

Not all States are imposing civil monetary penalties for each instance of serious or chronic violations, though they are permitted to do so. In addition, some States may not be aggressively trying to collect the imposed civil monetary penalties.

Abuse and neglect remains a significant problem. The additional survey task of examining a facility's abuse intervention system is being implemented, but the evidence of serious abuse and neglect persists. Last year in Virginia, ombudsman program complaints regarding abuse and neglect increased by 127 percent. Guidance on key quality of life and quality of care indicators has not reached all the concerned parties. While the indicators and protocols for nutrition, hydration, and pressure sores have been developed, apparently not all State ombudsmen have been invited to or made aware of available training on these protocols.

While we anticipate complete implementation of each of the initiatives, State ombudsmen believe there are additional areas which need to be addressed. Inadequate staffing continues to be the single biggest barrier to providing residents with a higher quality of care. Ombudsmen across the country continue to frequently hear of one certified nursing assistant having to provide care to 20, 30, or even 40 residents on a shift. This contributes to a higher risk of resident abuse and neglect, including malnutrition; dehydration; and pressure ulcers.

Quality of care indicators, enhanced oversight by State survey agencies, and educational campaigns are all critical components to the quality of care equation, but all these initiatives will fail to produce the desired result if nursing homes do not have adequate numbers of well-trained staff. Make no mistake: inadequate staff equals inadequate care.

Therefore, NASOP strongly recommends Federal requirements for minimum staffing. In addition, NASOP would like to see clear guidelines for pre-survey coordination and exchange of information between State survey agencies and ombudsman programs, including more advanced notice to ombudsmen of scheduled surveys prior to the day of the survey. This would allow local ombudsmen a better opportunity to participate in the survey process and to assist residents who may also wish to speak with surveyors.

We appreciate this opportunity today, and we hope we can continue an open dialog with this committee and with the Health Care Finance Administration. Thank you.

[The prepared statement of Mark Miller follows:]

Testimony of the National Association of
State Long Term Care Ombudsman Programs (NASOP)
To
The Senate Special Committee on Aging
September 23, 1999

Mr. Chairman, members of the Committee, I am Mark Miller, State Long-Term Care Ombudsman for the Commonwealth of Virginia. It is a privilege to speak with you today on behalf of the National Association of State Long Term Care Ombudsman Programs (NASOP), concerning HCFA's nursing home initiatives. We applaud this Committee's interest in benchmarking states' progress in implementing these initiatives to improve care, including the national campaigns to reduce the incidences of malnutrition, dehydration, pressure sores and resident abuse.

NASOP supports the federal HCFA initiatives to improve quality of care --- and while we recognize that progress is being made, much more needs to be done. At this point, I think it is fair to say that the implementation and measurable impact of these initiatives is uneven, both within and across states, and is yet to be fully recognized.

Surveys continue to be too predictable, and quality of care problems remain uncorrected for prolonged periods of time. State survey agencies with limited resources, and those with unionized surveyors, are experiencing difficulties fully implementing all the HCFA requirements to stagger surveys, conduct timely revisits, and investigate serious complaints within a reasonable timeframe. Enhanced monitoring of chronically noncompliant facilities is taking place, but is also diverting time from other survey agency responsibilities.

The Abuse Awareness Campaign has experienced a slow start. Ombudsman Programs in each of HCFA's ten regions volunteered to assist with the pilot campaign, but because of poor quality printing, education posters were recalled.

Not all states are imposing Civil Monetary Penalties (CMPs) for "each instance" of serious or chronic violations, though they are permitted to do so. In addition, some states may not be aggressively trying to collect imposed CMPs.

Abuse and Neglect is still a significant problem. The additional survey task of examining a facility's abuse intervention system is being implemented, but the incidence of serious abuse and neglect complaints persists. Last year in Virginia, ombudsman complaints concerning resident abuse, neglect and exploitation increased by 127%.

Guidance on key quality of life and quality of care indicators has not reached all concerned parties. The indicators and protocols for nutrition, hydration and pressure sores, have been developed, but apparently not all State Ombudsmen have been invited to, or made aware of available training on these protocols.

While we anticipate complete implementation of each of the initiatives, State Ombudsmen believe there are additional areas that need to be addressed.

Inadequate staffing continues to be the single biggest barrier to providing residents with a higher quality of care. Ombudsmen across the country frequently hear about a single certified nursing assistant (CNA) having to care for 20, 30 or even 40 residents on a shift. This **contributes to a higher risk of resident abuse and neglect, including malnutrition, dehydration, and pressure ulcers.** Quality care indicators, enhanced oversight by state survey agencies, and educational campaigns are all critical components to the quality care equation. But all these initiatives will fail to produce the desired result, if nursing homes do not have adequate numbers of well-trained staff. Inadequate staff = inadequate care. **Therefore, NASOP strongly recommends federal requirements for minimum staffing.**

In addition, NASOP would like to see clearer guidelines for pre-survey coordination and exchange of information between state survey agencies and Ombudsman Programs, including more advance notice to Ombudsman of scheduled surveys, prior to the day of the survey. This would allow local ombudsmen a better opportunity to participate in the survey process, and to assist residents who may wish to speak with surveyors.

We appreciate this opportunity today and hope we can continue an open and ongoing dialogue with this Committee, and the Health Care Financing Administration.

[This statement is given on behalf of the National Association of State Long Term Care Ombudsman Programs (NASOP), but is not a position paper adopted by the association.]

Dr. SCANLON. Thank you very much. Toby Edelman.

STATEMENT OF TOBY EDELMAN, NATIONAL SENIOR CITIZENS' LAW CENTER, WASHINGTON, DC

Ms. EDELMAN. Thank you. Although I have been asked to talk about two of the positive aspects of the initiative this morning, I would just like to summarize four points that I have made in the longer written testimony that I have submitted to the committee.

First, the Nursing Home Initiative, I believe is leading to some excellent revisions in the survey and enforcement processes that holds significant promise for improving quality of care and quality of life for residents, but more action is still needed to implement components of the initiative that have not yet been implemented and to establish additional changes that are necessary to make the survey and enforcement policies work correctly.

Third, I think full implementation of the initiative and these other necessary changes is not possible without substantial increase in the Federal and State survey budgets; and, finally, I think a number of the positive changes envisioned by this initiative are undermined and directly threatened by the nursing home industry's continuing opposition to various aspects of the initiative and to the industry's renewed attempts to establish an alternative survey system, something that they have been trying to do for many years and are renewing, yet again, now in North Dakota.

Fourteen months have passed since the President announced the Nursing Home Initiative, and I think there has been both good news and bad news in these fourteen months. The good news first: I think many of the specific components of the initiative represent constructive changes that have potential to improve the systems: increasing the unpredictability of surveys, imposing stronger sanctions more quickly when compliance is first identified, improving public access to timely and accurate information, referring cases of egregious abuse and neglect to the Department of Justice for appropriate civil and criminal prosecution, and strengthening Federal oversight of State performance are just several of the components that hold promise.

Some of these proposals have even begun to be implemented. We've heard, for example, this morning and from a lot of people that States are beginning to conduct surveys on nights and weekends, and they're identifying deficiencies in areas, such as under staffing, that residents and families have complained about for many years.

The Health Care Finance Administration also helped publish a rule earlier this year authorizing States to impose certain remedies without giving facilities an opportunity to correct, and we understand that States are very cautiously beginning to use this new authority. I'll talk about those two a little bit more later, but I think there is also a considerable amount of bad news.

Many parts of the initiative have not been implemented by either States or the Federal Government. We heard in this committee's June hearing that some States can't implement the directive to investigate complaints alleging actually harm within 10 days, even though they all recognize that's an important thing to be doing, be-

cause they don't have enough money and enough staff to handle that many complaints.

The Federal Government, for its part, has not implemented all parts of the initiative. The proposal to impose remedies when agencies cite deficiencies causing harm in two consecutive surveys—that Double G issue—remains still just a promise and not a reality. But I think even if all the parts of the initiative were implemented, they wouldn't be sufficient to bring about all the improvement that is necessary.

We need additional changes. For example, the most critical one to me is that the enforcement system needs to be refocused to make prompt imposition of remedies the rule rather than the exception. And there are two other points: the under financing and the industry opposition.

To talk briefly about the two positive things: The off-hours surveys, the initiative requires States to begin 10 percent of surveys on nights and weekends, and although Federal law has called for unannounced surveys for many years, even predating the 1987 reform law, a very common and frequent complaint are that surveys are entirely predictable, even if they are not officially announced.

The new direction to begin surveys at off hours is being implemented. We heard about a survey in July of this year where the Nevada team began a survey at 12:15 in the morning, Sunday morning, and the State had received nine complaints about inadequate staffing in that facility. During the midnight survey, the survey team found 209 residents in two buildings; and in one building where 92 residents lived, there were two licensed practical nurses, two certified nursing assistants on duty.

One of the CNAs told the surveyors this happens all the time, I am glad you are here to see it. The survey team identified eight residents whose bodies and clothing were saturated. Some were crying out for help, not getting help because there were so few staff people on duty, and the State cited a deficiency in nursing services.

Briefly about the "per instance" civil money penalty, this new rule that was published in March of this year authorizes States to impose remedies of $1,000 to $10,000 for an instance of noncompliance, whether or not there was actual harm or immediate jeopardy, and without determining the total number of days of noncompliance, and, significantly, without giving facilities an opportunity to correct.

In the preamble, HCFA gave a couple of examples. One was for violation of residents' privacy for which they suggested or gave a possibility of a $1,000 civil money penalty. I think this was incredibly welcome to advocates who have been very critical of the enforcement system's general failure to treat violations of residents' rights very seriously. I think in the preamble HCFA was very responsive to the concerns raised by the committee, the General Accounting Office, and consumers about the lax and tolerant enforcement system, and HCFA frankly acknowledged that it needed to strengthen its ability to impose remedies more promptly.

Before having a final conclusion, I just want to report a recommendation that I got from a State agency whose director called me yesterday morning and urged me on behalf of his staff to make this point. He said that their surveyors believe that the most im-

portant way to improve quality of care is to mandate a Federal staffing standard, and he wanted that as a State position.

So I think, in conclusion, the initiative has the potential to make a difference in quality of life and quality of care for residents, and most of the components of the initiative, if implemented, would improve the survey and enforcement systems that would be helpful; but implementation has been undermined by the staffing, by the funding inadequacies, and the industry' opposition.

I think we are very heartened by midnight surveys, as in Nevada, documenting inadequate staffing, but I think unless those findings are coupled with a strong enforcement response—not just an opportunity to correct, but some actual government response—residents won't be protected and the reform law's mandate will remain unfulfilled.

Thank you.

[The prepared statement of Toby Edelman follows:]

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CONSUMERS ASSESS THE NURSING HOME INITIATIVE

Senate Special Committee on Aging
September 23, 1999

The National Senior Citizens Law Center thanks the Senate Special Committee on Aging for its sustained commitment to improving quality of care and quality of life for nursing home residents. The three hearings held by the Committee between July 1998 and June 1999 and the Committee's ongoing oversight have helped bring about important changes in the way nursing homes are surveyed and enforcement actions are taken.

We also thank the Health Care Financing Administration (HCFA) for its work over the past year. With insufficient resources, HCFA staff have worked extraordinarily hard to develop and implement President Clinton's Nursing Home Initiative and the recommendations of the General Accounting Office and this Committee.

We appreciate the invitation to address the impact of the Nursing Home Initiative. I have four points to make this morning:

1. The Nursing Home Initiative is leading to some excellent revisions in the survey and enforcement processes that hold significant promise for improving the quality of care and quality of life for residents.

2. More action is still needed to implement components of the Nursing Home Initiative that have not yet been implemented and to establish additional necessary changes in federal survey and enforcement policy.

3. Full implementation of the Nursing Home Initiative and other needed changes are not possible without substantial increases in the federal and state survey budgets.

4. The positive changes envisioned by the Nursing Home Initiative are undermined and threatened by the nursing home industry's opposition to various aspects of the Nursing Home Initiative and renewed attempts to establish an alternative survey system.

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Fourteen months have passed since the President announced the Nursing Home Initiative. There is both good news and bad news about what the 14-month period has brought.

First the good news. Many of the specific components of the Initiative represent constructive changes that have the potential to strengthen the federal survey and enforcement systems. Increasing the unpredictability of surveys, imposing stronger sanctions more quickly when noncompliance is first identified, improving public access to timely and accurate information about nursing homes, referring cases of egregious abuse and neglect to the Department of Justice for appropriate civil and criminal prosecution, and strengthening federal oversight of state survey agency performance, are just several of the components of the 22-point Initiative that hold considerable promise.

Some of these good proposals have begun to be implemented. We have heard, for example, that states are beginning to conduct surveys on nights and weekends and are identifying deficiencies in areas such as understaffing that residents and families have complained about for many years. The Health Care Financing Administration also published a rule earlier this year authorizing states to impose certain remedies without first giving facilities an opportunity to correct their deficiencies. States are cautiously beginning to use this new sanction authority.

Next, the bad news. Many parts of the Initiative have not been implemented by either states or the federal government. We heard in this Committee's June hearing that some states have been unable to implement the directive to investigate complaints alleging actual harm within 10 days, even though they support the principle, because they do not have sufficient staff or money to respond to complaints within that time schedule. The federal government, for its part, has not implemented all parts of the Initiative. The proposal to impose remedies when state survey agencies cite deficiencies causing harm in two consecutive surveys remains a promise, not a reality.

Moreover, even if all parts of the Initiative were fully implemented, they would not be sufficient to bring about all the improvement that is needed in the survey and enforcement systems. Additional changes need to be made to these systems to assure that residents receive all the care and services that are mandated by the nursing home reform law. I offer two examples. The number of residents whose care is evaluated in some depth during the survey needs to be expanded, as the General Accounting Office has recommended. The care of too few residents is reviewed during the survey to enable surveyors to identify all the problems that residents experience. And the enforcement system needs to be refocused to make prompt imposition of remedies for deficiencies the rule, rather than the exception.

Two other points are critical as well. First, the federal and state survey and enforcement systems are seriously underfinanced. Good laws and good rules can

never be fully implemented without adequate funding for the survey process. There is not enough money in the system at present to support all the work that needs to be done.

Second, the nursing home industry needs to join states and the federal government and consumers in working to improve and strengthen the survey and enforcement processes, instead of opposing enforcement and attempting to replace the public regulatory system with a collaborative system of its own creation.

1. The Nursing Home Initiative is leading to some excellent revisions in the survey and enforcement processes that hold significant promise for improving the quality of care and quality of life for residents.

The Initiative contains revisions to the survey and enforcement systems that are beginning to make a difference for nursing home residents. For example:

A. Off-hour surveys

One of the changes made by the Nursing Home Initiative is the new direction to begin 10% of surveys on nights and weekends.[1] Although federal law has called for unannounced surveys for many years, a common and frequent consumer complaint has been that surveys are predictable, even if they are not officially announced. The new HCFA direction to begin surveys at off-hours is being implemented and is making a difference in identifying serious care deficiencies that residents and their families have complained about for many years.

For example, in July 1999, a Nevada survey team began a survey at midnight on a Saturday night. The state had received nine complaints about nurse staffing in this facility.

During the midnight survey, the survey team found 209 residents in two buildings. In one building where 92 residents lived, only two licensed practical nurses and two certified nurse assistants (CNAs) were on duty. As reported in the deficiency statement, one CNA told the surveyors, "'This happens all the time. I'm glad you all are here to see it... I'm always in charge of all the residents. They just had this agency CNA called in.'" The survey team identified eight residents whose bodies and clothing were saturated with urine and some with stool as well.

The state cited a deficiency in nursing services.

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[1] Transmittal No. 5, amending §7207 of the State Operations Manual (Jan. 1999). This direction does not seem to appear in Transmittal No. 10, which includes the July 1999 protocol.

B. Use of quality indicators in the survey process

A major innovation of the survey process that was implemented on July 1, 1999 is the introduction of quality indicators (QIs) to identify potential quality of care concerns and to help select the sample of residents whose care is reviewed in some depth during the survey. While more comprehensive use should be made of the extensive information that is contained in the QIs, the new process is beginning to establish a more accurate, focused, and defensible survey process.

Creative survey agencies are also using the QI reports in additional ways. For example, we have heard that some states are using QI reports to help evaluate and substantiate consumer complaints that they receive.

C. Per instance civil money penalties

In March 1999, the Health Care Financing Administration (HCFA) published a final rule with comment period establishing authority to impose per instance civil money penalties (CMPs) as an additional enforcement remedy.[2]

The rule authorizes states to impose per instance CMPs of $1000 to $10,000 for an instance of a nursing home's noncompliance, without regard to whether actual harm or immediate jeopardy has already occurred, without determining total number of days, or ending date, of noncompliance, and without first giving facilities an opportunity to correct.

In the preamble to the final rule, HCFA reports that, except in instances of immediate jeopardy or facilities identified as poor performers, CMPs "have not been imposed where facilities have been able to correct deficiencies before a predetermined date for the completion of correction."[3] As a result, facilities have avoided the imposition of CMPs "although subsequent to achieving compliance these same facilities have failed to maintain substantial compliance."[4] This pattern of "'yo-yo'" compliance was one of the problems with the federal enforcement system that Congress intended to correct when it enacted the 1987 nursing home reform law.

HCFA's new analysis of its authority under the 1987 reform legislation led the agency to conclude that "the statute offers greater flexibility" than HCFA had exercised and that states and the Secretary have authority to impose CMPs when they identify a deficiency, without first determining the total number of days of noncompliance.

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[2] 64 Fed. Reg. 13,354 (Mar. 18, 1999).

[3] *Id.* 13,355.

[4] *Id.* 13,556.

HCFA gives two examples of per instance CMPs that could be imposed under the new rule: $1000 for violation of a resident's privacy and $4000 for an avoidable pressure sore. HCFA's example of a resident's rights violation as a sanctionable deficiency is especially welcome to consumers, who have been critical of the enforcement system's failure to treat residents' rights violations seriously.

In the preamble to the final rule, HCFA was responsive to the concerns raised by this Committee, the General Accounting Office, and consumers about the lax and overly-tolerant enforcement system that has allowed most facilities an opportunity to correct deficiencies before remedies are considered for imposition. HCFA frankly acknowledged the need to strengthen its and states' ability to impose remedies more promptly. The changes are also responsive to the Institute of Medicine's 1986 recommendation that the enforcement system impose remedies for the existence of deficiencies, not just for failure to correct deficiencies.[5]

The March 1999 rule also authorizes states to impose certain remedies directly, rather than having to make recommendations about remedies to HCFA's Regional Offices. This aspect of the final rule attempts to streamline and eliminate unnecessary delays in the enforcement system. It also establishes a different relationship between states and the federal government and respects the appropriate roles of both.[6]

We have heard that state survey agencies are cautiously beginning to use the new

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[5] Committee on Nursing Home Regulation, Institute of Medicine, *Improving the Quality of Care in Nursing Homes* (Mar. 1986). The IoM Committee report was the basis of the 1987 nursing home reform law.

[6] The enforcement system established in the State Operations Manual (SOM) issued in July 1995 gave the federal government exclusive authority to impose remedies against facilities that participate in the Medicare program, regardless of the extent of their participation. At the same time, it limited state enforcement authority to facilities that participate solely in the Medicaid program. In all instances where the Regional Office was the decision-maker (i.e., for all facilities that participate in the Medicare program), the SOM authorized states to *recommend* remedies to the Regional Office, but said that the Regional Office *imposed* the remedies. The SOM then expressly added that "in all but the most unusual circumstances," the Regional Office would be expected to impose whichever remedies the state recommended. HCFA officials described the Regional Offices as providing "rubberstamp" approval.

Such a framework – in which states do not have direct authority to impose remedies and Regional Offices do no more than attach their official seal of approval to states' recommendations – trivializes both the state and federal roles. This system is time-consuming, perpetuates paperwork, and effectively nullifies statutory language that describes tie-breaking enforcement rules when state and federal officials disagree about which remedies to impose in particular situations. *See* NSCLC, "What Happened to Enforcement? Part II: The Experiences of Five States," *The Nursing Home Law Letter*, 1998, Issue No. 3, pp. 23-24 (Oct. 16, 1998). Preparation of this publication was supported by a grant from the Commonwealth Fund, a New York City-based private foundation.

The provision of the per instance CMP rule granting states more authority to impose remedies is a beginning step in realigning federal and state roles in enforcement.

CMP authority to impose sanctions against facilities with significant deficiencies.

2. More action is still needed to implement components of the Nursing Home Initiative that have not yet been implemented and to establish additional necessary changes in federal survey and enforcement policy.

The Initiative contains many provisions that have not yet been fully implemented, due to lack of staff and money. For example, in March, HCFA issued new directions to states to investigate complaints alleging actual harm within 10 days.[7] This component of the Initiative has not been widely implemented due to states' lack of money to conduct complaint investigations within this time period. HCFA has not implemented the GAO's July 1998 recommendation to expand the size of the resident sample.

Additional changes to the survey and enforcement systems, beyond those set out in the Nursing Home Initiative, are also needed, however:

A. New enforcement draft

HCFA has now circulated a new draft of the enforcement provisions of the reform law.

We have not yet received a copy of the draft. However, we understand that the draft reverses prior HCFA policy and *correctly implements* the reform law's enforcement provisions by setting out a new presumption that enforcement agencies will impose remedies immediately when they identify deficiencies, rather than give facilities yet another opportunity to correct their deficiencies before facing the possibility of sanctions. If this draft becomes official HCFA policy and is fully implemented by HCFA and states, it will represent an enormous improvement in the federal enforcement system that will offer new protection to residents.

B. New survey tools and remedies are needed for deficiencies in residents' rights and quality of life

The Nursing Home Initiative has understandably focused on concerns about egregiously poor care. HCFA has awarded a contract to develop quality indicators for matters involving quality of life. The survey process and appropriate remedies for quality of life and residents' rights must receive priority attention in HCFA.

C. The survey and enforcement systems need to develop mechanisms to prevent poor outcomes that are avoidable

While the survey and enforcement systems have been focused on identifying poor care

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[7] Letter from Sally K. Richardson, Director, Medicaid and State Operations, HCFA, to State Survey Agency Directors (Mar. 16, 1999).

that exists and on imposing sanctions when poor outcomes occur, HCFA also needs to develop mechanisms that *prevent* poor outcomes that can be avoided when facilities provide residents with appropriate care and services. As the California Supreme Court recognized in a 1997 decision, public regulatory systems are intended to *prevent* poor outcomes, not merely to impose sanctions after the fact. *California Association of Health Facilities v. Department of Health Services*, 940 P.2d 323, 65 Cal.Rptr. 872, 885 (1997).

An enforcement system that promptly and reliably imposes sanctions when poor outcomes are cited would of course help deter poor outcomes in the future. The changes proposed by HCFA in the new enforcement draft are apparently moving in this direction.

Nevertheless, in addition, an enforcement system must intervene earlier in the care delivery process to impose remedies in instances where harm has not yet occurred but is likely to occur if the poor facility practices continue. There appears to be universal acceptance that a facility should be cited and sanctioned for failure to have an infection control system in place, even if no residents have yet developed avoidable infections. A similar intolerance of other poor practices that will inevitably lead to poor outcomes is also necessary and needs to be incorporated into the regulatory system.

Finally, the federal enforcement system must reflect facilities' compliance with all the standards of the reform law. Since the reform law's care standards became effective in 1990, federal law has mandated that residents receive appropriate care and services to *attain and maintain* their highest practicable functioning. The absence or prevention of avoidable decline is a necessary component of evaluating a facility's performance, but it is not sufficient. Some residents are expected to improve. The enforcement system must, ultimately, impose remedies if residents do not achieve expected improvement.

3. Full implementation of the Nursing Home Initiative and other needed changes are not possible without substantial increases in the federal and state survey budgets.

The federally-mandated survey and certification process is seriously underfinanced.

The federal survey budget has been virtually stagnant since 1992,[8] although the scope

[8] In 1998, the federal government gave states $147 million to conduct certification surveys of skilled nursing and nursing facilities; receive, investigate, and resolve complaints; and take appropriate enforcement action against facilities that have deficiencies. In 1992, the federal survey budget was $145 million. While state survey agencies devote the majority of their time and resources to nursing homes, they are responsible for a full range of health care providers, including home health agencies, end-stage renal disease facilities, acute care hospitals, psychiatric hospitals, hospices, ambulatory surgical centers, rural health clinics, outpatient therapies, comprehensive outpatient rehabilitation facilities, portable x-ray providers, and other facilities serving Medicare and Medicaid beneficiaries. In

of work for survey agencies has expanded enormously. At present, the amount of money spent by the federal government on survey and enforcement activities to assure that the care it paid for was properly provided to residents is considerably less than half of one percent of the federal cost of care -- an inadequate sum to determine whether appropriate care is provided to some of the most vulnerable members of our society.

The budget for HCFA is equally inadequate. There are too few staff people available in HCFA's Central Office to do all the work that is needed to develop the survey and enforcement systems, to train state and federal surveyors, to set policy, and to answer questions.

Appropriate enforcement is not possible without adequate resources. The lack of meaningful enforcement allows poor care to continue.[9]

Other financial issues undermine the effectiveness of the survey and enforcement systems. For example, only a handful of Administrative Law Judges are assigned to hear nursing home appeals for the entire country. As a consequence, there is a multi-year backlog on administrative hearings for appeals of civil money penalties and other remedies.[10]

4. The positive changes envisioned by the Nursing Home Initiative are undermined and threatened by the nursing home industry's opposition to various aspects of the Nursing Home Initiative and renewed attempts to establish an alternative survey system.

The nursing home industry opposes various aspects of the Initiative through litigation and administrative advocacy. An additional serious concern is that the industry is

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addition, survey agencies must conduct validation surveys of accredited providers and investigate allegations of patient dumping by acute care hospitals.

[9] The correlation between inadequate enforcement and poor care outcomes is not limited to nursing homes. A GAO report on the certification and enforcement systems for home health agencies found that pervasive noncompliance with standards was allowed to thrive when the public regulatory system did not work. GAO, *Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies*, GAO/HEHS-98-29 (Dec. 1997). The GAO reported that home health agencies can easily achieve initial certification and that once certified, "serious deficiencies in the [recertification] process allow problems to go undetected." *Id.* 3. The survey evaluates compliance with only five of 12 conditions of participation, and even when a survey agency identifies deficiencies, it imposes no remedies. The GAO concluded that public regulation of home health agencies is essentially a "self-policing" system that does not work. *Id.* 19. "[T]he threat of termination has little, if any, deterrent value, and problem HHAs seem to operate with impunity." *Id.* 20.

[10] All remedies under the reform law other than civil money penalties may be imposed during the pendency of an administrative hearing. 42 U.S.C. §§1395i-3(h)(5), 1396r(h)(8). In practice, however, other remedies have not been imposed either because the State Operations Manual permits almost all facilities a prior opportunity to correct their deficiencies.

continuing to promote development of an alternative survey process that would undermine the progress that is being made through the Nursing Home Initiative.

A. Per instance CMP rule

The American Health Care Association (AHCA) has challenged the per instance CMP rule in federal court,[11] arguing that HCFA did not have statutory authority to promulgate a rule authorizing per instance CMPs and that the agency did not provide the public with advance notice and an opportunity to comment, in violation of the Administrative Procedures Act. The case does not challenge the use of per instance CMPs in any particular instance. It challenges HCFA's authority to establish this additional remedy under any and all circumstances.

The National Citizens' Coalition for Nursing Home Reform, the national advocacy organization that represents residents and consumers, has intervened in the litigation as defendant in order to support the legality of the rule.

B. Immediate remedies for "double G" deficiencies

The Initiative called for the imposition of immediate remedies, without an opportunity to correct, for facilities that in two consecutive surveys were cited with deficiencies at a level causing actual harm to residents.[12] While HCFA implemented this component of the Initiative for deficiencies at a pattern or widespread scope (boxes H and above on the federal enforcement grid), it has delayed implementation for isolated deficiencies at box G. HCFA contends that resource limitations have led to the delay. The nursing home industry's opposition may be another factor.

At the Committee's request, the General Accounting Office evaluated a random sample of 107 "G" deficiencies selected from 10 large states during fiscal year 1998.[13] At the June 30, 1999 hearing, the GAO reported that it agreed with 98% of the G-level deficiencies cited by states.[14] It also reported that the G-level deficiencies reflected serious care issues:

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[11] *American Health Care Association v. Shalala*, No. 1:99 CVO 127 (D.D.C. May 18, 1999). AHCA has now filed a motion for summary judgment and defendants have filed a motion to dismiss.

[12] Memorandum from Richard P. Brummel, Acting Director, Disabled and Elderly Health Programs, Center for Medicaid and State Operations, to Associate Regional Administrators and State Agency Directors, "Change in Mandatory Criteria Used to Make 'Poor Performing Facility' Determination" (Sep. 22, 1998).

[13] GAO, *Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit*, 2, GAO/HEHS-99-157 (Jun. 1999).

[14] *Id.* 2, 5. Testimony of Dr. William Scanlon, Director, Health Financing and Public Health Issues, U.S. General Accounting Office, Washington, DC, http://www.senate.gov/~aging/hr35ws.htm.

Survey reports depicted repeated examples of actual harm, including pressure sores, broken bones, severe weight loss, burns, and death. The five most commonly cited deficiencies involved

- failure to prevent or treat pressure sores (23 percent);
- failure to prevent accidents (14 percent);
- failure to ensure adequate nutrition (8 percent);
- failure to provide acceptable quality of care (6 percent); and
- failure to prevent mistreatment, neglect, or abuse (4 percent).[15]

The GAO's extraordinary endorsement for states' G-level findings fully supports HCFA's policy decision to allow immediate imposition of remedies for double G deficiencies. Yet implementation of that policy has been delayed.

C. Education campaign on abuse and neglect

When HCFA announced a new education campaign to help nursing home residents and their families "identify and report incidents of abuse and neglect" and invited the nursing home industry's voluntary participation, both AHCA and the American Association of Homes and Services for the Aging (AAHSA) expressed disapproval of the poster that HCFA developed.[16]

D. Alternative survey protocol

AHCA has announced plans to work with the health department in North Dakota to develop an alternative survey process as a "pilot" test.[17]

Several years ago, AHCA developed a waiver proposal that would have allowed the survey agency in South Dakota to use an alternative collaborative survey process. HCFA eventually rejected the waiver proposal. Residents' advocates opposed the waiver as a matter of public policy and demonstrated that the nursing home reform law

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[15] *Id.* 5-6.

[16] "AHCA Unveils Dignity Initiative As Alternative to HCFA Poster Campaign: Educational Program to Stress Abuse Awareness, Prevention," (Jun. 28, 1999), http://www.ahca.org/brief/nr990628c.htm.

"AHCA Calls for Collaboration, Not Confrontation with Administration: AHCA Pushes for a 'Better Way' of Improving Health Care for Seniors," (Jun. 30, 1999), http://www.ahca.org/brief/nr990630.htm.

"AAHSA Views New Quality Indicators As a Positive Step in the Survey Process" (Jul. 2, 1999), http://www.aahsa.org/public/pr111.htm.

[17] "Shalala Expresses Support for Alternative Survey Process," *AHCA Notes*, Vol. XXVIII, No. 8, p. 3 (Aug. 1999).

does not authorize states to use an alternative survey protocol under any circumstances.

We are concerned that a "pilot" will have much the same purpose as the waiver – creating a collaborative project between the regulatory agency and the regulated industry that replaces the current system of public information and public accountability. While we have seen few details about the North Dakota pilot, we are concerned that the pilot would test a process that is both poor public policy and impermissible under the reform law.

CONCLUSION

The Nursing Home Initiative has the potential to make a difference in residents' quality of care and quality of life. Most of the components of the Initiative, if fully implemented, would improve the survey and enforcement systems in ways that would offer more protection to nursing home residents. Implementation of the Initiative is undermined by inadequate federal funding of survey agencies and by the nursing home industry's opposition.

The nursing home survey and enforcement systems also need to be strengthened in additional ways beyond the changes contained in the Initiative. The lax and overly tolerant enforcement system that the GAO described in July 1998 needs to be reoriented so that deficiencies, when cited, are sanctioned by appropriate enforcement consequences.

Consumers are heartened by the Nevada survey agency's midnight survey that documented inadequate staffing, among other deficiencies. But unless the findings are coupled with a strong enforcement response, residents will not be protected and the nursing home reform law's mandate – that each resident receive care and services to attain and maintain his or her highest practicable physical, mental, and psychosocial well-being – will remain unfulfilled.

The National Senior Citizens Law Center is a non-profit public interest organization and law office, established in 1972, that represents the interests of older poor people and provides technical assistance to their advocates.

Toby S. Edelman
September 17, 1999

Dr. SCANLON. Thank you very much. Ms. Clayton.

STATEMENT OF JANET CLAYTON, FAMILY MEMBER OF A NURSING HOME RESIDENT, NEOSHO, MO

Ms. CLAYTON. Yes. Good morning.

For over 6 years, since 1993, my father has resided in a nursing home located in the middle of our small town. My father practiced law in this community for more than 50 years and served as a Circuit Court judge. When my mother died, I became my father's guardian. My father's diagnosis is Parkinson's disease. He is a private pay resident, and so far, including associated expenses, has spent about $245,000 for nursing home care.

All nursing home residents are completely vulnerable to the care their facilities choose to provide. With few exceptions, I spend about 2 hours daily with my father and privately employ a person to often feed him. To discuss my father's history of bedsores, skin tears, bruises, dehydration, pneumonia, and numerous urinary tract infections in today's short time would be impossible. I will only recount a recent injury that I believe demonstrates the critical need for more thorough complaint investigations.

March 24, 1999, only 5 days after the Division of Aging staff visited the facility to help obtain appropriate treatment for my father's two bedsores, he received a serious injury. This happened supposedly, according to facility reports, in the shower. Somehow the top of my father's head was gashed open and his hand and arm badly bruised. I accompanied him to the emergency room where he received stitches. I photographed my father's injuries.

There were supposedly two aides in the shower room with my father. One aide said she was busy drying the floor. The other aide claimed to be standing directly in front of my father, but her memory of what else he was doing at that time is inconsistent. My father hasn't walked since 1993, and his physical ability is so limited that he can't turn himself in bed. The story that he was able to throw himself, for no reason, past the standing aide is very difficult to believe. How could a 20-year-old aide be unable to break his fall or react faster than my sick, 85-year-old father? How could the top of his head receive such a deep gash?

The investigation didn't address these questions. The surveyor did not take photographs of the shower area. I asked. The emergency room physician was not interviewed nor x-rays examined. The report didn't eliminate the possibility of abuse or that my father was negligently left alone and fell against the sharp object or was dropped.

How often have residents been dropped or injured here? I know that other family members have complained about their loved one's injuries, such as fractured ribs, during the past year. Do all those injuries have to be identical to substantiate a pattern and, if so, at whose expense?

Basically, the facility was cited only for failure to use the recently purchased reclining shower chair. Failing to use a new chair was not the only problem. Resident safety is dependant upon truly thorough investigations and appropriate citations. Incomplete investigations don't serve as deterrents.

Residents here continue to receive injuries in varying situations. Such reports distort statistics. There is already consumer confusion with facilities' self-reported incidents versus family complaints and with isolated incidents versus pattern situation. So much is left to interpretation at the distance.

The President's initiatives include ensuring that nursing homes are in compliance with standards before lifting sanctions. This facility was in noncompliance in 1994, 1995, 1996, and 1997. June 1998, this facility was again found to be in noncompliance with a survey report of 34 pages. The next month, the revisit determined a situation unimproved, and the report grew to 69 pages.

December 1998's visit found continuing failure to attain substantial compliance. Yet, in April 1999, a month after my father's injury, a survey team with a new leader finally found the facility to be deficiency free, the seal of approval. Even as I report this, my father has another sore on his hip and a urinary tract infection, the third infection just this month. Wouldn't this facility qualify as a repeat offender or an example of yo-yo compliance?

My testimony today has focused on my father's pains and injuries, but my current experience with nursing home care also includes my aunt who resides in another area facility. Her experiences have included falls, cuts, pneumonia, and over medication.

I appreciate the forum allowing families to present their concerns in the continuing pursuit of improved care for the helpless elderly in nursing homes. I thank you for the studies and the programs being developed, but I stress the urgency of your help. For the residents, every hour spent staring at a wall is so lonely. Every day sitting wet is humiliating. Every week without adequate food and liquid is inhumane, and every month with a bedsore is unbearable.

Thank you.

[The prepared statement of Janet Clayton follows:]

TESTIMONY SUBMITTED
to the
UNITED STATES SENATE SPECIAL COMMITTEE ON AGING

By
Janet Clayton
Neosho, Missouri

September 23, 1999

Senator Grassley and distinguished members of this committee, thank you very much for inviting me to testify as a consumer today regarding my experiences with nursing home care.

For over six years, since 1993, my father has resided in a nursing home, located in the middle of our small town. My father practiced law in this community for more than 50 years, and served as a Circuit Court Judge. When my mother died, I became my father's guardian.

My father's diagnosis is Parkinson's disease. He is a private pay resident, and so far, including associated expenses, has spent about $245,000 for nursing home care. All nursing home residents are completely vulnerable to the care their facilities choose to provide. With few exceptions, I spend about two hours daily with my father, and privately employ a person to often feed him.

To discuss my father's history of bedsores, skin tears, bruises, dehydration, pneumonia, and numerous urinary tract infections in today's short time would be impossible. I will only recount a recent injury that I believe demonstrates the critical need for more thorough complaint investigations.

On March 24 of this year, only five days after Division of Aging staff visited the facility to help obtain appropriate treatment for my father's two bedsores, he received a serious injury. This happened supposedly, according to facility reports, in the shower. Somehow, the top of my father's head was gashed open, and his hand and arm badly bruised. I accompanied him to the emergency room where he received stitches. I photographed my father's injuries.

There were supposedly two aides in the shower room with my father. One aide said she was busy drying the floor. The other aide claimed to be standing directly in front of my father, but her memory of what else she was doing at that time is inconsistent. My father hasn't walked since 1993, and his physical ability is so limited that he can't turn himself in bed. The story that he was able to throw himself (for no reason), past the standing aide is very difficult to believe. How could a 20 year-old aide be unable to break his fall or react faster than my sick, 85 year-old father? How could the top of his head receive such a deep gash?

The investigation didn't address these questions. The surveyor did not take photographs of the shower area. I asked. The emergency room physician was not interviewed, nor x-rays examined.

The report didn't eliminate the possibility of abuse, or that my father was negligently left alone and fell against a sharp object, or was dropped. How often have residents been dropped or injured here? I know that other family members have complained about their loved ones' injuries such as fractured ribs, during the past year. Do all injury situations have to be identical to substantiate a pattern? If so, at whose expense?

Basically, the facility was cited only for failure to use the recently purchased reclining shower chair. Failing to use this new chair was not the only problem.

Residents' safety is dependent upon truly thorough investigations and appropriate citations. Incomplete investigations don't serve as deterrents (residents here continue to receive injuries in varying situations). Such reports distort statistics. There is already consumer confusion with facilities' self-reported incidents vs. family complaints, and with isolated incidents vs. pattern situations. So much is left to interpretation at a distance.

The President's Initiatives include ensuring that nursing homes are in compliance with standards before lifting sanctions. This facility was in noncompliance in 1994, 1995, 1996 and 1997. June 1998 this facility was again found to be in noncompliance, with a survey report of 34 pages. The next month, a revisit determined the situation unimproved and the report grew to 69 pages. December, 1998's revisit found "Continuing Failure to Attain Substantial Compliance." Yet in April 1999, a month after my father's injury, a survey team with a new leader finally found the facility to be deficiency free, the 'Seal of Approval'. As I write this, my father is recovering from recent blisters on his hip and a urinary tract infection. Wouldn't this facility qualify as a 'repeat offender', or as an example of 'yo-yo' compliance?

My testimony today has focused on my father's pain and injuries. But my current experience with nursing home care also includes my aunt who resides in another area facility. Her experiences have included falls, cuts, pneumonia and over-medication.

I appreciate your forum allowing families to present their concerns, and your continuing pursuit of improved care for the helpless elderly in nursing homes. Thank you for the studies and programs being developed. But I stress the **urgency of your help**. For the residents, every hour spent staring at a wall is so lonely, every day sitting wet is humiliating, every week without adequate food and liquid is inhumane, and every month with a bedsore is unbearable.

Thank you.

Janet Clayton

NURSES NOTES

BEVERLY

DATE	TIME	COMMENTS
03/22/1999		
15:50		[redacted] 0862-001-1-00003 S Assessed areas from escoriation on coccyx and right buttock, maceration noted on coccyx and surrounding open area on right buttock. Area on coccyx, measures .3x.3cm and area on right buttock measures 1x1cm. Tx continues with Granulex Spray. Incontinent of both bowel and bladder. :Carolyn Booth. ADON// Signature CBooth lpn

[redacted] corrected SR.
corrected SR

INIT. ATTENDING PHYSICIAN: Adams A. | ROOM NO.: 38 | RESIDENT NO.: 91798

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF AGING
COMPLAINT INVESTIGATION REPORT

P. 01/02

3145263642

MAR-24-1999 11:30

1. REPORT NUMBER	2. CLASS	3. INCIDENT DATE	4. FIPS	5. REGION	11. RECEIVED FROM	12. DATE	13. TIME	14. LINE #	15. CRU WORKER
I999 083 071	II	3/24/99	29145	7	#30	3/24/99	11:16	8	DMP

7. FACILITY NAME	16. Referred by CRU to Region	CALL	FAX	MAIL	DATE	TIME	INIT
Beverly Healthcare						11:25	DMP

8. FACILITY ADDRESS	17. AN Letter Sent	18. CROSS REFERENCES.
330 S. Wood St	☐ YES ☐ NO	

9. FACILITY TELEPHONE	19. DWH LICENSED	20 LEGAL SERVICES NOTIFIED
(417) 451-3600	☐	☐ DATE:

9. FACILITY CITY	10. FACILITY NUMBER	10. PROVIDER NUMBER
Neosho 64850	056611 A/FG	265458

NARRATIVE OF REPORTED INCIDENTS

21. ITEM #		22. CLASS	23. NAT.	24. RECLASS	25. STATUS
1.	#1 was in the shower room in a shower chair w/ 2 staff present. The staff reached around #1 to get more soap + #1 jerked (he has spastic movements) + pulled away from staff. #1 slipped out of chair + hit the top of his head on the wall of the shower stall. #1 received a laceration + was taken to ER where he received 2 stitches. Family notified.		GS		A

181/CRU

5. DEFICIENCIES CITED: F324, 13CSR 15-14.042(66) II

27. RECEIVED IN REGIONAL OFFICE	28. INVESTIGATION INITIATED DATE / TELEPHONE / FIELD	29. INVESTIGATION INITIATED WITHIN	30. DATE OF EXIT	31. NEXT OF KIN NOTIFIED
DATE ▶ 3-24-99 TIME ▶ 11:30	DATE ▶ 3/24/99	☐ 24 HRS ☐ 90 WORK DAYS ☐ OTHER	3/24/99	☐ YES ☐ NO DATE: 3/24/99 - ons. te

32. WAS DURING	33. REVIEW?	34. REPORT ATTACHED TO	35. RELATED WITH COMPLAINT #	36. REFERRALS RECOMMENDED (OTHER AGENCIES)
☐ INSP/SURVEY	☐ YES ☐ NO	☐ THIS COMPLAINT		☐ NO ☐ YES WHICH AGENCIES?

37. INVESTIGATOR (SIGNATURE/TITLE)	DATE	38. REGIONAL MANAGER OR DESIGNEE APPROVAL (SIGNATURE/TITLE)	DATE
Laura Emerson FSII	5/8/99		

886-1025 (2-97) DISTRIBUTION: WHITE - CENTRAL OFFICE; CANARY - CRU; PINK - REGIONAL OFFICE MA 380 (12-97)

38

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

APR 19 1999

ATG
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
\	265458	A. BUILDING _____ B. WING _____	3/24/99

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEVERLY HEALTH CARE OF NEOSHO	330 SOUTH WOOD STREET NEOSHO, MO 64850

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 324	Continued From page 1 they consider a safety risk. She said the CNAs who give showers know which residents should use the reclining shower chair and it is communicated to them by word of mouth. On 3/24/99, at 9:55 a.m., a CNA gave Resident #1 a shower in the shower room on hall two. He fell to the floor while seated in a shower chair and hit his head on the wall. He sustained a two and a fourth inch laceration to his forehead. Staff took him to a hospital emergency room where he received ten stitches to his forehead. He returned to the facility that afternoon. On 3/24/99, the CNA who had given Resident #1 the shower said she was standing directly in front of him when she turned briefly to put soap on a washcloth. She said he jerked and threw himself out of the chair to her right and hit his head. She said there was a second CNA in the shower room who was drying the floor around them. She said a charge nurse has told her to use the reclining shower chair when bathing Resident #1, and she has used it in the past. She said the last time she gave him a shower he also jerked. She said she didn't use the reclining shower chair this time because, "It just didn't come to me". The second CNA who was in the shower room said she has given Resident #1 a shower in the past and used the reclining shower chair. She said that he jerks and it is very difficult to keep him positioned. A third CNA said she always uses the reclining shower chair when bathing Resident #1. She said	F 324	construed as agreement with allegations of non-compliance or admission by the facility. This plan of correction is submitted as this facility credible allegations of compliance. The facility will ensure that each resident receives adequate supervision and assistive devices to prevent accidents. Resident #1 was reassessed and care plan updated to address his involuntary movement. CNA instructions also address interventions for involuntary movement and safety. The interventions were discussed with the legal guardian and with agreement verbalized. Resident does wear a vest device (supplied by daughter) for trunk support and not to restrain him. He is assessed with trunk instability. Measures taken to ensure other residents at risk are not subject to deficient practice are: -residents assessed on admission and every 3 months or prn for positioning and safety issues. -care plans to address interventions to	03-24-99 03-24-99 4-12-99

MEL CARNAHAN
GOVERNOR

MISSOURI
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF AGING
P.O. BOX 1337
JEFFERSON CITY
65102-1337
TELEPHONE: 573-751-3082

RELAY MISSOURI
for hearing and speech impaired
TEXT TELEPHONE
1-800-735-2966
VOICE
1-800-735-2466

July 22, 1999

Ms. Janet Clayton
517 W. Hickory
Neosho, MO 64850

Dear Ms. Clayton:

This letter is in response to your letter dated May 17, 1999 in regard to injuries sustained by your father at Beverly Health Care of Neosho. It is my understanding that regional office staff in Springfield have been in contact with you throughout the investigation process and that you have been informed of the results of the investigation.

The facility was cited under federal regulations requiring adequate supervision by staff and the use of appropriate assistive devices since it was determined that the facility had identified a different shower chair as more appropriate but failed to use it. The facility was also issued a class II violation under state requirements for protective oversight and supervision. The revisit conducted on April 28, 1999 determined that the facility had corrected the violations.

The division is responsible for identifying and citing regulatory violations, as well as to insure the protection of vulnerable elderly and disabled citizens. It was determined that the facility corrected the situation which led to the incident during which injuries occurred to your father. It is our intention to insure that such corrections occur in order to provide for resident safety. The division does utilize the imposition of harsh enforcement penalties for facilities which are not cooperating with the corrections imposed through the regulatory process or which are unable to achieve effective and sustained correction. DA Institutional Services' (IS) investigation substantiated that the injury should not have occurred to your father. DAIS does not condone poor practices which harm residents.

I do appreciate your concerns for your father in this facility. Your willingness to get involved and to pursue the problems you identified have complemented the efforts of the division to identify and effect corrections in this facility. However, as a result of our investigation into this incident, we have determined that the facility has corrected the problem and no further enforcement activities are necessary.

Andrea J. Routh
Director

AJR/AKW

SUPPORTING STATEMENT FOR TESTIMONY OF JANET CLAYTON
September 23, 1999

To The Senate Special Committee on Aging:

As the caregiver of my mother who resides in the same nursing home facility as the speaker's father, I would like to relate some experiences concerning my mom.

On the night of October 3, 1998, or very early the next morning (Oct. 4), my mother suffered two broken ribs. The orthopedist said, probably from being dropped. (At the time, two uncertified aides were transferring the patients on her hall.) She was not sent to the ER for X-rays until the afternoon of October 4, and then only because she kept crying out in pain. The facility's "back up" doctor was then on call in the ER. He claimed that he could see nothing on her X-rays except some arthritis. After a brief examination, during which she cried out at every touch, he recommended painkillers and sent her back to the facility with me. After she returned, the facility's DON examined her in bed and did nothing further, so I contacted Mom's physician. The next day he examined her and ordered further X-rays. These revealed two broken ribs, plus a broken elbow that probably occurred between examinations. He ordered an arm sling, use of a Triple lift, help in feeding and painkillers. The facility reported this incident only after Mom had suffered for 36 hours with no treatment except Tylenol. I filed a claim which the state investigated and validated, but, to my knowledge, there was no citation, fine, or other penalty of any kind.

In April 1999, just before the facility was found "deficiency free", I had reported my mother's weight loss of nine lbs. (from 116 to 107) in one month, because I felt she was not receiving enough help in feeding. Apparently, this problem was not considered a deficiency.

Betty Whillson
Neosho, MO
417 451-5730

Nursing home faces one-week deadline

By Wally Kennedy
Globe Staff Writer

NEOSHO, Mo. — Beverly Health Care has until Dec. 18 to correct several violations relating to patient care.

If it doesn't, it will lose its Medicare money.

If that happened, the nursing home might have to close. The 85 or so residents, most of whom rely on Medicare and Medicaid, could receive 30-day notices in which they or their families would have to find new places for them to live.

Another possibility is that the nursing home could be sold to another company that would enter the market with a clean slate and not face the violations that now are causing trouble for Beverly Health Care, 330 S. Wood St.

But, state and company officials said the nursing home could fix the problems by Dec. 18 and return to a position of good standing with the Missouri Division of Aging.

See Home, Page 10A

The Joplin Globe

Friday, December 11, 1998

Continued from Page 1A

Dan Springer, vice president of public affairs for the Fort Smith, Ark.-based company, said: "We feel confident we will get the issues resolved by that time. We filed a plan of corrective action, but did not achieve all of the things we hoped to achieve. We are aggressively addressing those issues, which are staffing-related matters.

"We have a new management team that has instituted new accountability measures in that facility. We think the new management team will create a high level of quality care."

As to the possibility that a new owner might be found, he said: "Our focus is on making sure we meet the requirements. I would prefer not to speculate on the future."

Paul Shumate, deputy director of institutional services for the Division of Aging, said: "We're real hopeful. We don't like to displace residents unless there is no other option. We view the system as being more remedial than punitive."

The nursing home's problems started in June when the Missouri Department of Health said human dignity and quality of life were lacking for some patients at Beverly Health Care, formerly known as the Neosho Senior Center. Beverly has operated the home for 12 years.

The report said the home did not provide adequate health care for residents suffering from incontinence, did not provide adequate activities for residents and lacked adequate staffing.

A plan of correction was filed July 22 with the state, and the home was permitted to continue participating in state and federal reimbursement programs.

But, subsequent inspections showed that the problems were not being corrected.

"We did an unannounced survey (inspection) within 90 days of that report and found them not to be in compliance," Shumate said. "They had difficulties in giving residents assistance with daily living. They received an additional 90-day period to come into compliance. We cannot extend it any longer.

"If they do not correct the problems by Dec. 18, their Medicare program will be terminated."

The nursing home has a history of problems. State records show it was cited for noncompliance with state regulations during inspections in March 1994, May 1995, May 1996 and June 1997.

In May 1995, the inspection found 15 violations in such areas as patient dignity, care plans, proper treatment to prevent bed sores and properly prepared food. In December 1997, complaints were filed with the state after a male patient with Alzheimer's disease had sexual relations with a female resident. The complaint alleged lack of protective oversight.

The last inspection was Nov. 30 through Dec. 2. Although the nursing home has had six months in which to correct patient-care problems, inspectors made the following allegations:

- The staff did not maintain acceptable practices for residents' hygiene, primarily incontinent care and toilet use.
- Two residents who requested these basic needs were ignored by direct-care staff.
- A resident at risk of skin breakdown had open sores. Staff members were slow in notifying the physician for treatment orders and in providing pressure relief.
- A resident with pain from rib fractures was not assessed and monitored routinely for pain medication, nor for behaviors that the staff treated with anti-psychotic drugs.
- Some alert residents became incontinent and were soaked with urine.

Shumate said the nursing home has taken steps to improve operations since that inspection.

"If they work hard prior to the 18th, they may be able to substantiate compliance," he said. "With another visit, they may be in compliance."

If the home is not in compliance by that date, residents would not be forced out the next day, Shumate said the residents would have 30 days in which to find new homes.

"This sort of thing does not happen very often," Shumate said. "The facility really tries to avoid such a serious situation. If it can't, a new operator will step in, pump in the money and meet compliance. But, it is really a blow to the company when they lose compliance."

JoAnn Freeborn, former executive director of the Area Agency on Aging in Southwest Missouri, said: "Quite frankly, I don't think it's a problem at all for them to find available beds. I believe there are available beds in alternate facilities.

"I believe they will come up with an answer at the 11th hour and come into compliance. It may be that they unload it. Another company will purchase it and give it a whole new name. The new company would have no compliance problems. They would start with a clean slate."

Dr. SCANLON. Thank you very much. Mr. Korber.

STATEMENT OF KIMM KORBER, FAMILY MEMBER OF A NURSING HOME RESIDENT, WASHINGTON, WV

Mr. KORBER. Yes. I want to thank Senator Grassley and the other members of the committee today for the opportunity to speak. I would like to say that the subject of nursing home care is complicated. The issues are many. The affected parties are going to be found at every turn, and the challenge of sorting all that out is enormous.

I certainly want to commend the Clinton Administration, in particular members of this committee, for making a commitment and taking the initiative necessary to begin to improve the process that we are talking about today. I think a foundation has been laid at the national level to make substantive changes in what acceptable quality nursing home care will come to mean in this country; however, the story I am about to share with you supports the contention that more needs to be done at the interface between the State agency level and the nursing homes where matters of enforcement and compliance have to occur.

Again, my name is Kimm Korber, and I am here today on behalf of my mother, Bettie Korber, who is a nursing home resident. At the outset, let me say it would be very comforting to think that nursing homes could be perfect. I know they can't be. At the same time, I firmly believe that the family members and the residents of nursing homes should expect no less than reasonable treatment and consideration from the nursing home industry and the agencies chartered to monitor that industry.

As mentioned in the beginning, my mother suffered a debilitating stroke in 1990, and she has been a resident of a nursing home since that time, and after being released from the hospital, she was admitted to a Beverly Enterprise Nursing Home in Murrysville, Pennsylvania, and since that time, there has been many issues regarding the consistency of her care and the quality of her care, dignity, and communication.

Understanding the purpose of the forum today. I am going to just briefly discuss some things that have occurred in the last 18 months with my mother, and, again, I would emphasize this is a partial summary, what I am about to describe to you.

In less than 12 months, my mother's right leg was fractured twice while in the care of the Beverly staff. The second fracture occurred after commitments had been made by the Beverly staff to take preventive measures to prevent another fracture from occurring. Despite knowing that my mother was diabetic, a deep ulcerated bedsore in her right heel was allowed to form. That heel is still deformed to this day and is painful to her.

Bettie has been left to sit in cold excrement and urine for as much as 3½ hours, despite an order from her physician that she be checked for incontinence every 2 hours because her bottom had deteriorated so badly. She has also—as we have heard mentioned, people talking about urinary tract infections—developed a series of urinary tract infections for which the facility has offered no explanation, and another bedsore was allowed to develop on her right

leg where a splint had been put on where it had rubbed the skin raw.

Now, beginning in August 1998 and continuing into May 1999, I attempted to resolve these and other concerns directly with the facility's executive director and the director of nursing services. My inquiries and requests for information were deflected, ignored, or answered in the most general or evasive of terms. In February 1999, the executive director had written me a letter indicating that I was, "Not and never will be satisfied with the care provided to my mother" at Beverly Health Care, Murrysville, and then made clear the facility was willing to assist me in finding somewhere else for my mother to go.

I asked what reasonable person would be satisfied with the care that my mother had been receiving and what she had been suffering through and how many broken bones were going to be acceptable in less than 12 months time. Those are some of the very questions that I asked the executive director and today I have yet to have an answer, and that is certainly something Beverly Enterprises has avoided trying to answer as well.

Since I was unable to resolve those concerns about my mother's care by contacting the administration, I reached out beyond the facility and contacted, among others, in May 1999, the Pennsylvania Department of Health as well as Boyd Hendrickson who is the president and chief operating officer of Beverly Enterprises. From Mr. Hendrickson I received a four-sentence letter stating the organization would investigate the situation, but to date I have heard nothing further.

From the Pennsylvania Department of Health—and I want to commend them for taking an interest in Bettie's case—a surprise survey of the facility was done in June 1999. From this survey, a number of deficiencies were identified, including a finding that Beverly staff had not affirmatively investigated or developed interventions to resolve the concerns I had addressed.

In response to the survey's findings, the facility's administrators prepared a plan of correction for each cited area. Not surprisingly, this plan was couched in terms stating that the preparation and execution of the plan was in no way an admission or agreement that the allegations or citations were factual. Further, it was clearly stated the plan of correction was prepared solely because it was required by the provision of Federal and State laws.

While, Beverly's legal posturing is apparent in their plan of correction, given what my mother factually suffered through, I was and still am at a loss to see even a scintilla of concern expressed for human dignity or injury in their response. My mother is 74 years old and does have certain medical concerns unrelated to her residency in a nursing home; however, Beverly's response ignores any acceptance or acknowledgement that their actions or lack of actions contributed in any way to my mother's injuries. Bettie certainly didn't injure herself, and these injuries were preventable.

One of the outfalls of the survey was Beverly's preparation of a care plan. It is an 18-page document, and on the surface, it appears to be rather substantial until you examine it closely and recognize that a great deal of what the facility says it will do as a part of this plan is not routinely documented. Therefore, based on the fa-

cility's documentation, it will be difficult at best for any survey agency to verify compliance to the care plan, and even with the surprise inspection, agency representatives would largely be limited to direct observation to validate the procedures—at least on the day they were present—are being followed.

Rather than debate what the facility committed to do on paper, I think it would be fair to say that a much better test of the facility's integrity and commitment to improve outcomes would be what has happened to my mother since the care plan was implemented in July and August 1999. A little over a month later, on September 2, 1999, Bettie was admitted to the hospital with pneumonia, dehydration, and an impacted bowel. Her admission to the hospital came only after a family member had stopped by the facility, recognized that she was in distress, and then prompted the Beverly staff to respond. I am not a medical professional, but I can assure you Bettie didn't suddenly develop pneumonia or become dehydrated or impacted that day.

There are a few other points members of this forum should know. First, the Murrysville facility proudly displays a 1998 quality award from the American Health Care Association for providing quality care to their residents. Apparently, broken legs are not recognized as a quality of care issue.

Second, in May 1999, the group vice president responsible for the Murrysville facility sent out a customer survey encouraging responses so that the quality of care provided could be improved. Given the lack of response to the concerns I addressed to the facility about the quality of care provided to my mother, I personally found the Beverly survey to be disingenuous.

Third, the executive director of the facility I have referenced is pictured on the front cover of Beverly Enterprises' 1998 annual report. Inside that front cover is listed the mission, vision, and values of Beverly Enterprises, an Arkansas-headquartered company. I think the events I have described today speak volumes about Beverly's values of integrity, passion, and commitment.

Thank you.

[The prepared statement of Kimm Korber follows:]

TESTIMONY OF KIMM A. KORBER

Thank you Senator Grassley and the other members of the committee for the opportunity to speak today. The subject of nursing home care is complicated, the issues are many, and affected parties will be found at every turn. The challenge of sorting these matters out is enormous and I want to commend the Clinton Administration and in particular, this committee's members, for making the commitment and taking the initiatives necessary to improve the quality of care provided to nursing home residents. I think a foundation has been laid at the national level to make substantive changes in what acceptable, quality nursing home care will come to mean for this country. The story I am about to share with you supports the contention that more work needs to be done to impact what is happening at the level where state agencies and nursing home facilities interact over matters of compliance and enforcement.

My name is Kimm Korber and I am here today on behalf of my mother, Bettie Jane Korber, who is a nursing home resident. At the outset, let me say it would be comforting to believe that nursing homes can be perfect, but I know they simply never will be. At the same time I also firmly believe nursing home residents and their families deserve and should expect no less than reasonable treatment and consideration from the nursing home industry and those agencies chartered to monitor the industry.

My mother suffered a debilitating stroke in 1990 and has been a nursing home resident since that time. After being released from the hospital, Bettie was admitted to a Beverly Enterprise nursing home in Murrysville, Pennsylvania and since her admission, there have been many issues regarding the consistency of her care, the quality of her life, and communications with the facility's administration. Understanding the purpose of this forum today, I will only focus on events occurring during the last eighteen (18) months. Let me share with the members of this forum a <u>partial</u> summary of those events:

- In less than twelve months, Bettie's right leg was fractured twice while in the care of Beverly's staff. The second fracture occurred after commitments made by the Beverly staff to take preventative measures to insure against additional fractures were not applied.
- Despite knowing that Bettie was diabetic, a deep ulcerated bed sore was allowed to develop on the heel of her right foot. The tissue on her heel remains deformed to this day.

- Bettie had been left to sit in cold excrement and urine for as much as three and a half hours despite an order from her physician that she be checked for incontinence every two hours because her bottom had deteriorated so badly.
- Bettie developed a series of urinary tract infections for which the facility has offered no explanation.
- Another bed sore was allowed to develop on her right leg where her splint had rubbed the skin.

Beginning August 1998 and continuing into May 1999, I attempted to resolve these and other concerns with the facility's Executive Director and Director of Nursing Services. My inquiries and requests for information were deflected, ignored, or answered in the most general or evasive terms. In February 1999, the Executive Director had written me a letter indicating that I was "not and never will be satisfied with the care provided" to my mother at Beverly Healthcare-Murrysville and then made clear that the facility was willing to assist in finding "somewhere" else for my mother to go. What reasonable person would have been satisfied with the "care" my mother had been suffering through? How many broken bones are acceptable in less than 12 months time? These are some of the questions the Executive Director and others at Beverly Enterprises have avoided answering.

Since I was unable to resolve concerns about my mother's care by contacting the Executive Director or Director of Nursing Services, I reached out beyond the facility and contacted among others in May 1999 the Pennsylvania Department of Health and Boyd Hendrickson, President and Chief Operating Officer of Beverly Enterprises.

From Mr. Hendrickson I received a four sentence letter stating the organization would investigate the situation, but to date I have heard nothing further. From the Pennsylvania Department of Health, and I want to commend them for taking an interest in Bettie's case, a surprise survey of the facility was done in June 1999. From this survey a number of deficiencies were identified, including a finding that Beverly's staff had not affirmatively investigated or developed interventions to resolve the concerns I addressed.

In response to the survey's findings, the facility's administrators prepared a plan of correction for each cited area. Not surprisingly, this plan was couched in terms stating that the preparation and/or

execution of the plan was in no way an admission or agreement that the allegations or citations were factual. Further, it was clearly stated the plan of correction was prepared solely because it was required by the provision of Federal and State laws.

While Beverly's legal posturing is apparent in their plan of corrections, given what my mother factually suffered through, I was and still am at a loss to see even a scintilla of concern expressed for human dignity or injury in their response. My mother is 74 years old and does have certain medical conditions unrelated to her residency in a nursing home; however, Beverly's response ignores any acceptance or acknowledgement that their actions or lack of actions contributed in any way to my mother's injuries. Bettie certainly did not injure herself and these injuries could have been prevented.

One of the outfalls of the survey was Beverly's preparation of a Care Plan. It is an 18-page document and on the surface it appears to be rather substantial until you examine it closely and recognize that a great deal of what the facility says it will do as a part of this plan is not routinely documented. Therefore, based on the facility's documentation, it will be difficult at best for any survey agency to verify compliance to the care plan and even with a surprise inspection, agency representatives would largely be limited to direct observation to validate that procedures – at least on the day they were present - are being followed.

Rather than debate what the facility committed to do on paper, I think it would be fair to say that a much better test of the facility's integrity and commitment to improved outcomes would be what has happened to my mother since the care plan was implemented in July/August 1999.

A little over a month later, on September 2, 1999, Bettie was admitted to the hospital with pneumonia, dehydration, and an impacted bowel. Her admission to the hospital came only after a family member had stopped by the facility, recognized that Bettie was in distress, and then prompted Beverly's staff to respond. I am not a medical professional but I can assure you that Bettie didn't suddenly develop pneumonia, or become dehydrated and impacted the day the family member visited.

There are a few other points members of this forum should know. First, the Murrysville facility proudly displays a 1998 Quality Award from the American Health Care Association for providing quality care to their residents. Apparently, broken legs are not recognized as a quality care issue. Second, in May 1999, the Group Vice President responsible for the Murrysville facility sent out a customer survey encouraging responses so that the quality of care provided could be improved. Given the lack of response to the concerns I addressed to the facility about the quality of care provided to my mother, I personally found the Beverly survey to be disingenuous. Third, the Executive Director of the facility I have referenced is pictured on the front cover of Beverly Enterprises' 1998 Annual Report. Inside the front cover is listed the mission, vision, and values of Beverly Enterprises; an Arkansas headquartered company. I think the events I have described today speak volumes about Beverly's values of integrity, value, passion, and commitment.

I came here today to be Bettie's voice with the hope of bringing some meaning to what she has endured and suffered through. I know that if the situation were reversed, my mother would be here today for me, and so I could not do anything less for her. There is nothing that I, or anyone else, can say or do to change what Bettie has experienced. By sharing her story with you, I hope it prompts the members of this forum to look hard, very hard, at how the care provided in nursing homes is monitored, regulated, and enforced. With a new millenium nearly upon us and along with it millions of Baby Boomers posed to enter their Golden Years, this country will be facing an insurmountable crisis in the care and treatment of our elderly citizens if we don't act responsibly now. Thank you.

Dr. SCANLON. Thank you very much. Ms. Lenhart.

STATEMENT OF DEANNE LENHART, KANSAS ADVOCATES FOR BETTER CARE, INC., LAWRENCE, KS

Ms. LENHART. I am here today representing Kansas Advocates for Better Care, the only Statewide independent nonprofit organization in Kansas that advocates for better long-term care. I thank the committee for giving me this opportunity to participate.

I want to start off by saying that I believe that the President's initiatives alerted the nursing home industry in Kansas that they are under public scrutiny. One initiative, the unannounced inspection surveys at irregular times, provides some assurance to consumers that the Government is concerned about the quality of care during evening hours and on weekends.

Another initiative, the posting of information survey results on the internet, provides consumers a source of information when seeking a nursing home for placement of a loved one.

Other initiatives remain of concern to me. Specifically, I continue to be concerned about, (1) an improved management information system; (2) a national standard for minimum staffing hours of nursing care per resident day; and (3) the prospect of terminating funding to States that failed to adequately perform survey functions.

Concerning the management information system, we consumers need, one, information about the extent and nature of complaints against a facility. We second need notification that a facility had requested an informal dispute resolution; and third, we need an improved procedure for handling complaints. Consumers need information about complaints and IDRs because these items provide background insight on the character of a long-term care provider, and consumers who file complaints with the State long-term care ombudsman and with the State departments that staff abuse and neglect hot lines should be provided timely and adequate responses.

The following situation occurred in Kansas. November 4, 1998, Tom Klammer of the Kansas City metropolitan area placed his father in a nursing home. Later that month, he called Kansas Advocates to discuss how to proceed with several complaints about the nursing home in which his father had resided. After complaining to the facility, without satisfactory resolution, he moved his father to another home and filed a complaint with the Kansas Department of Health and Environment Abuse and Neglect hot line and with the Kansas long-term care ombudsman.

In March 1999, the State wrote him that they could not substantiate any of the allegations. Unsatisfactory responses compelled him to call and/or write the Kansas Elder hot line, State legislators, and Kansas Congressional members. In May, he received a full refund of charges for his father's stay in the nursing home.

It took Mr. Klammer more than 6 months of unrelenting communications to obtain some satisfaction concerning his complaint about his father's care; however, very few people have the energy and tenacity of Mr. Klammer. The burden of relentless communications should not be placed on the family. The procedures for reporting and investigating complaints must be improved.

I have these improvements to suggest: first, require that within 1 week of filing, every complainant receive confirmation that their complaint has been received, a case number, and a priority number, along with disclosure of the timeframe for the investigation. Second, require that every complainant receive a written confirmation of a completed investigation, along with pertinent details of the investigation and the findings. Third, require that the investigation be thorough and include details of interviews with pertinent staff, residents, and family members.

Now concerning the nursing staff hours per resident day, we consumers need a federally mandated minimum of staffing ratios that fit the increased acuity of current nursing home residents, because there is no consistency across the country. I am pleased that the committee will soon hold a forum to discuss this issue.

Finally, concerning possible termination of funding to States that fail to adequately perform survey functions, the nursing home initiatives have raised the bar for the expected performance of State survey departments. We consumers hope that the Federal Government will demonstrate its willingness to support this needed additional oversight, by increasing funds for State survey departments.

Thank you.

[The prepared statement of Deanne Lenhart follows:]

United States Senate Special Committee On Aging
Thursday, September 23, 1999

Testimony Prepared by
Deanne Lenhart

My name is Deanne Lenhart and I am the Executive Director of Kansas Advocates for Better Care. It is the only independent statewide non-profit organization in Kansas that advocates for quality long-term care for adult care home residents. We were founded in 1975 and have a membership base of more than 500 persons. I thank the Committee for giving me the opportunity to participate in this forum.

I believe that the President's Initiatives alerted the nursing home industry that they are under public scrutiny. One initiative, unannounced inspection surveys at irregular times, provides some assurance to consumers that the government is concerned about the quality of care during evening hours and on weekends. Another initiative, the posting of inspection survey results on the Internet, provides consumers a valuable source of information when seeking a nursing home for placement of a loved one. I trust that additional Internet information on nursing homes will be available soon.

Other initiatives remain of concern to me. Specifically, I continue to be concerned about:

(A) An improved management information system;

(B) A national standard for minimum staffing hours of nursing care per resident day;

(C) The prospect of terminating funding to states that fail to adequately perform survey functions or fail to improve inadequate survey systems.

(A) Concerning the management information system - we (consumers) need (1) information about the extent and nature of complaints against a facility, (2) notification that a facility had

requested an informal dispute resolution (abbreviated as IDR), and (3) an improved procedure for handling complaints. Consumers need information about complaints and IDRs because these items provide background insight on the character of a long-term care provider. And, consumers who file complaints with the State Long-term Care Ombudsmen and with the State Departments that staff abuse and neglect hotlines should be provided timely and adequate responses.

The following situation occurred in Kansas. November 4th of 1998, Tom Klammer, of the Kansas City metropolitan area, placed his father in a nursing home. Later that month he called Kansas Advocates to discuss how to proceed with several complaints about the nursing home in which his father had resided. One complaint was that his father missed vital medications because the nursing home allowed prescriptions to run out and failed to notify anyone. Mr. Klammer found this out during a visit to his father. A second complaint was that his father was told his room was to be in the new wing of the home. When his father moved in, they placed him in an old wing and it was explained that the new wing was for private-pay residents; his father was getting ready to apply for Medicaid. There were other complaints, such as the call light that did not work. After complaining to the facility without satisfactory resolution, he moved his father to another home and filed a complaint with the Kansas Department of Health and Environment "abuse and neglect hotline" and with the Kansas Long-Term Care Ombudsman. In March, 1999, the state wrote him that they could not substantiate any of his allegations. Unsatisfactory responses compelled him to call and/or write the Kansas Elder Law Hotline, state legislators and Kansas congressional members. He also used a third party Internet site for investors to post complaints. Early Spring he received a partial refund for his father's 13-day stay. Rather than cash the check he continued to insist that the problem had not been resolved. In May he received a full refund of charges for his father's stay in the nursing home. The attached pages give more details about his ordeal.

It took Mr. Klammer more than six months of unrelenting communications with numerous nursing home corporate VIPs, state government employees, state legislators and Kansas congressional members to obtain some satisfaction concerning his complaint about his father's care. Other consumers in Kansas have called Kansas Advocates with complaints about poor care. We provide them information and contact phone numbers within the system. However, very few people have the energy and tenacity of Mr. Klammer. The burden of relentless communications should not be placed on the family. The procedures for reporting and investigating complaints must be improved.

I have some these small, incremental improvements to suggest:

(1) Require that within one week of filing, every complainant receive (a) confirmation that their complaint has been received, (b) a case number, and (c) a priority number along with disclosure of a time frame for the investigation.

(2) Require that every complainant receive written confirmation of a completed investigation, along with pertinent details of the investigation such as dates, persons interviewed, and the findings of the investigation.

(3) Require that the details of the investigation demonstrate thorough interviews with nursing staff, residents, and family members.

These suggestions may seem insignificant but consumers tell us that some of their dissatisfaction with the system is because of the lack of communication from the "abuse hotline" and from the "ombudsman". Consumers want to be acknowledged and kept informed of progress on their filed complaints.

(B) Concerning nursing staff hours per resident day - We (consumers) need a federally-mandated minimum of staffing ratios that fit the increased acuity of current nursing home residents because there is no consistency across the country. I am pleased that the Committee will soon hold a forum to discuss this issue.

(C) Concerning possible termination of funding to states that fail to adequately perform survey functions - The nursing home initiatives have raised the bar for the expected performance of state survey departments. Survey tasks that include more frequent surveys for poor performing homes and thorough inspections for complaints of abuse and neglect require a reasonable increase in funding. We (consumers) hope that the federal government will demonstrate its willingness to support this needed additional oversight by increasing funds for state survey departments.

Again, thank you for this opportunity to participate in the forum. I want to leave you with this statement. We have a complex but workable system for provision of long-term care. Many of those involved within this system - HCFA, nursing homes, state survey departments, consumer advocate groups, residents - sincerely want good quality care for our country's frail adults. I believe that a better quality of long-term care can result from making these improvements.

Kansas Advocate News

Kansas Advocates for Better Care

Volume 18, Issue 2 March 1999 Deanne Lenhart-Executive Director

Abuse Hotline, '98 Report

The Kansas Department of Health and Environment (KDHE) has provided a summary of calls to the toll-free Abuse Hotline during 1998. Of the calls received, 3,239 cases were investigated. 1,763 were coded as abuse, neglect or exploitation of an adult care home resident. The remaining cases were coded as complaints on care issues.

For 1,386 of the 1,763 cases of abuse, neglect or exploitation, nursing homes were allowed to "self-investigate" the case and report their findings to KDHE. On-site investigations were made by KDHE in only 385 of 1,763 cases. Those investigations resulted in 262 deficiencies cited against nursing homes and 312 alleged perpetrators being identified. **Kansas Advocates support on-site investigations by KDHE for *all* cases coded as abuse, neglect or exploitation.**

Throughout the 1990s, the number of abuse, neglect or exploitation cases investigated has increased dramatically. In 1992, there were 2,046 investigated cases. On average, there have been about 200 more cases each year between 1992 and 1998. **Kansas Advocates support punishing perpetrators, providing information and training on prevention of such abuse, and extending hotline hours to cover evenings and weekends.**

Member Feedback

Tom Klammer of Overland Park, provided Kansas Advocates extensive information about care/neglect complaints he recently voiced to an Overland Park nursing facility, which is part of a national chain. In addition to his father's not getting the room promised, his father missed several days of medications because the facility did not refill the prescription. Mr. Klammer moved his father to another facility, but also attempted to get apologies and a refund from the first facility. Nothing seemed to get their attention until he happened to find an Internet site about the national chain's stock market reports. He used that site to state his concerns regarding the care provided. After that, Mr. Klammer received several communications from the national office and the local facility.

He is still seeking to resolve his complaint, but believes that his effort on the Internet helped motivate the corporation to take his concerns seriously.

He also called the toll-free Elder Law Hotline (see page 3) and received general advice about how to proceed with his concerns, and with his communications with the nursing facility.

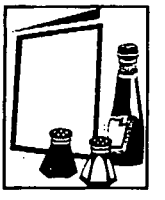
(NOTE: Mr. Klammer had initially called KABC last fall for information about homes for his father. He has since become one of our newest members!)

Annual Meeting Reminder

Friday, March 26, 1999
Noon to 2:30 p.m.
Castle Tea Room
1307 Massachusetts, Lawrence

Meeting Agenda

- Annual Report
- Election of Board Members
- Legislative Update - Carolyn Middendorf, RN
- Promoting Oral Health among Elderly Kansans Program Update
- FIND Facility Reports Demonstration, Ravi Bhaskar, KDPS
- Volunteer Recognition
- 1999 Projects and KABC Future
- Luncheon Speaker - Ardie Davis from Kansas Department on Aging, "Effective Advocacy"



Luncheon Choice

Chicken Piccata over Rice or Vegetarian Pasta
$8.00 per person.

Please RSVP on the form provided on page 4, or call 785-842-3088 **no later than Friday, March 19th.**

Kansas Advocate News

Kansas Advocates for Better Care

Volume 18, Issue 3 June 1999 Deanne Lenhart-Executive Director

Grant Awarded by KDOA

KABC received another grant from the Kansas Department on Aging. We plan to make at least ten presentations in nursing facilities on "Compassionate Care for Adult Care Home Residents." Targeted for the training are facilities with deficiencies concerning abuse, neglect and exploitation issues.

All licensed nursing facilities in Kansas were invited to participate. Presentations are planned in these cities: Arkansas City, Atchison/Hiawatha, Colwich / Mount Hope, Ottawa, Oskaloosa, Phillipsburg, St. Paul / Chanute, Leavenworth and Kansas City / Overland Park.

We invite members to order the 20-page booklet, ***"Compassionate Care for Adult Care Home Residents."*** It contains definitions of compassionate care and traits of those caregivers, resident rights, legal definitions of abuse, neglect and exploitation, as well as a list of those required to report abuse and penalties for not reporting. Also included is a toll-free telephone number for reporting suspected abuse and neglect, and actual cases from KDHE files. Order by mail or phone - $2.00.

1998 KABC Annual Report Summary

Kansas Advocates provided more services in 1998 than in 1997. Almost 300 requests for nursing home information were processed. Nearly 750 persons received quarterly newsletters. Almost 300 nursing home staff received training on preventing abuse and neglect or on preventing malnutrition.

Kansas Advocates revised and printed the popular "Consumer's Guide to Kansas Adult Care Homes."

The FIND database (Facility Information for Nursing home Decisions), funded by the Kansas Health Foundation, was established.

Member Feedback by Tom Klammer

In November 1998, I placed my father in an Overland Park nursing home. Two weeks later, we got him out, and I filed a complaint with the state against this facility. They let my father's vital medications run out and he missed several doses.

In March, the state declared in a letter they could not substantiate any of our allegations after interviewing me and my brother, as well as staff at the home. This was discouraging, as they never talked with either of us.

I recently got a letter from a VP of the home's Corporate Owner. In a complete turnaround from earlier communications, he promised to refund "all monies paid by you to our .....center in Overland Park." The same day, I received a copy of a letter that a state senator had written to KDHE asking them to reopen their investigation into our complaints. A few days later the Kansas Long-Term Care Ombudsman called me, said the governor asked him to look into my father's case and help me get it resolved. Recently I have had phone conversations with an aide to a US congressman, who is looking into this matter. The nursing home and the state are no longer ignoring the problems my father had. I finally got response from the company after posting information to their stockholders on the Internet, and writing to the CEO at their national headquarters.

I have written to elected officials, and KABC has given me a lot of good information about whom to contact, such as the Elder Law Hotline, as well as moral support. We all pay a lot of tax dollars and many residents and caregivers pay huge amounts of their own funds for quality care. Corporations should not be allowed to take the money and not provide the services.

(call in your feedback to KABC 800-525-1782)

Kansas Advocate News

Volume 18, Issue 4 Sept. 1999 Deanne Lenhart-Executive Director

Kansas Advocates for Better Care

Kemper Foundation Awards Grant

KABC received a grant from the William T. Kemper Foundation of Kansas City. This gift allows KABC to provide one copy of the "Consumers Guide to Kansas Adult Care Homes" to each library, senior center, area agency on aging and long-term care unit within hospitals in Kansas.

Now, anyone wanting to know how to evaluate the quality of a nursing home can read the 60-page booklet at one of the several locations in Kansas.

Bronson Legacy Received

Ms. Elsie Bronson of Topeka, who passed away in February of 1998, left KABC a bequest of $10,000. Ms. Bronson's generosity is very much appreciated by each of us involved with KABC.

Her thoughtful gift provides us with the funds to continue working toward making necessary improvements in the area of long-term care.

With the guidance of Board Member *Evie Curtis*, KABC hopes to make a "Leave a Legacy" program available for our supporters.

KABC Welcomes New Board Member

The staff and Board extend a warm welcome to *Evie Curtis* of Kansas City, the newest member of the Kansas Advocates Board of Directors. She fills a vacant position on the Board.

Ms. Curtis is a Vice-President with Bank of America, and has been involved with programs for the aging and elderly for many years.

She brings her experience, caring and energy to our board, and we look forward to her perspective on long-term care issues.

Member Feedback

Tom Klammer Follow-up

In our June newsletter, we reported member Tom Klammer's difficulties with an Overland Park nursing home. His father had not been receiving prescribed medications properly. After several difficult months of discussion with the L-T Care Ombudsman office, letters to elected officials and posting information to stockholders via the Internet, we are pleased to report Mr. Klammer was refunded (in May) all money paid to the home. KABC commends Mr. Klammer for his initiative and persistence to follow through with a difficult situation, and we are pleased that he obtained good results for his efforts.

Congratulations to...

Rita Martin, a long-time KABC member from Leavenworth, was recently recognized by the city for her volunteer work at Medicalodge of Leavenworth. Her husband has been a resident of the nursing home for several years. Mrs. Martin has given a great deal of time to the other residents by calling Bingo games several days a week. Mayor Ken Bower presented the Nursing Home Care Week Proclamation to Mrs. Martin in May to honor her ten years of volunteer work. KABC congratulates Mrs. Martin on the receipt of her award, and thanks her for being there for other residents of the home.

Dr. SCANLON. Thank you very much.

Since we have one more panelist, if you have got questions, if you would jot them down and pass them to the aisle, then we will be able to move into the discussion period.

Elma Holder, please.

STATEMENT OF ELMA HOLDER, NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM, WASHINGTON, DC

Ms. HOLDER. Good morning.

Our National Citizens Coalition is grateful for the continuing efforts of this committee to advance the quality of care for residents of nursing homes. Although we are here today to talk about the status of current reform initiatives, it is vital that we acknowledge those thousands of residents and their families who are suffering today from neglect and abuse, receiving care that fails to meet national minimum standards.

Most progress in regulatory reform, however important, does not answer the problems of today's residents. I myself have had the personal experience of monitoring two elderly friends' care in a Pennsylvania nursing home for the last year, visiting there as regularly as I could, mostly on weekends; and although the two residents—one who died just 2 weeks ago—are paying privately for their care at over $5,000 a month, I assure you my visits have shown me that they have not been receiving good care, including not being given assistance at meals.

So the consumers' sense of urgency for change is well founded and grounded in the reality that regulatory change is often painfully slow. Our organization has been working since 1975. We have seen a lot of initiatives come and go. We applaud this committee and especially Senator Grassley in its determination to hold the Health Care Financing Administration and the nursing home industry accountable to the public. We also believe that HCFA staff, as rushed and pressured as they are, for the most part have really responded to this initiative enthusiastically and are working hard to move it forward, regardless of the criticisms that they face.

The nursing home system's entrenched and systemic problems do not change overnight. Individual consumers and advocacy groups across the country hold important knowledge about the failure of the survey and enforcement systems and the resulting substandard care, neglect, and abuse.

This forum offers an important opportunity. Consumers in all States need regular occasions to speak out and be listened to carefully by people making decisions about changing the nursing home system. We urge Congressional Senators and Representatives and Government officials to hold similar meetings and hearings throughout the country.

A stronger week-to-week oversight of HCFA activities is needed to see that the initiatives do not slip and that implementation actually results in changes in nursing home conditions for residents. Even though the Senate committee has provided valuable oversight to hold HCFA accountable for its activities, NCCNHR believes that more oversight is needed.

We offer the following recommendations which we think will help: Mr. Scanlon spoke of monitoring progress. We need to achieve

oversight and coordination on these and future initiatives. We recommend that HCFA employ a highly qualified person, experienced in nursing home issues, to be a special adjunct to the HCFA administrator. Although she has listened carefully to consumers, she obviously has many more things to do than just nursing home reform and cannot listen to us all. A new high level point person should work exclusively to oversee the initiatives and be available to respond to the ideas and concerns of consumers.

The direct day-to-day experiences of family members such as we have heard today should be solicited regularly and heard at the administrator's level in order to learn of the actual effect of the initiatives. A special task force should be appointed at the secretary's level, composed primarily of a qualified experienced research team as well as representatives from the OIG, GAO, and the Justice Department and other skilled advocates who can help analyze what effect the initiatives are having on caregiving at the nursing home level.

Congress is urged to increase HCFA funding to support these initiatives. HCFA's regional offices are uneven in the way they oversee regulatory and enforcement activities. A full study should be conducted so that the effectiveness of the HCFA regional offices can be fully determined and needed changes made to help assure that implementation proceeds.

One of the obstacles to quick and effective enforcement efforts is the informal dispute resolution process. This system was fought for and won by the nursing home industry, but was opposed by the consumers. Congress should call for a study of the IDR by the GAO or the OIG, or both, to determine what explicit effect the IDR has had on surveys and enforcements.

States must be given sufficient survey budgets to increase the survey sample size. Surprise visits at evening time, nights, and weekends should continue aggressively in the States. I was in a meeting with about 90 nursing assistants in Baltimore, MD last fall. At that meeting, one of the nursing assistants stood up and said that the best three working days of her year were when the survey team was in the facility. When the survey occurred, it was consistent that the nursing home hired extra people to come into work, so that made her work easier during those 3 days.

Complaint investigations by most State agencies are weak and need more direct consumer information, as was said before me. States must develop an active advisory group of residents, family members, consumer advocates, and ombudsmen to assist them in improving their complaint investigation systems. HCFA should do the same at the national level.

Serious problems are found in nursing home chains and corporations. Consumers are waiting for HCFA to develop strong guidelines for how States are to share information about corporations operating nationwide. This information can be used for stronger enforcement.

HCFA should require facilities to post the working staff roster on every shift so that families and residents will know who is there to care for the residents. This can also be used to determine the level of staffing on any given shift.

HCFA should require Federal uniform cost reports for both Medicaid and Medicare with core elements and common definitions. States would be able to add other elements as needed. This approach would allow HCFA providers and consumers to understand how money is spent and to compare the results with quality indicators.

Since the 1980's, NCCNHR has advocated for HCFA to provide facility ownership information for consumers. Consumers need specific contact information about individual and corporate owners so that they can approach them to report serious care problems in facilities. This will help with public accountability in a system in which providers voluntarily sign a contract with the Government that they will meet national minimum standards.

HCFA and Congress must find new ways to support and strengthen the involvement of family members and citizen advocates. This forum is such a step.

Finally, NCCNHR urges Congress and HCFA to recognize that time and time again when family members, residents, ombudsmen, advocates, workers, and others are asked what is the most serious issue to tackle in nursing homes, staffing is the answer.

We thank you for being able to submit these comments today.

[The prepared statement of Elma L. Holder follows:]

CONSUMERS ASSESS THE 1998-99 NURSING HOME INITIATIVE
SENATE SPECIAL COMMITTEE ON AGING
September 23, 1999

The National Citizens' Coalition for Nursing Home Reform, presented by Elma L. Holder, Founder.

The National Citizens' Coalition for Nursing Home Reform is grateful for the continuing efforts of this Committee to advance quality of care for residents in nursing homes. Although we are here today to talk about the progress of reforms, it is critical that we acknowledge those thousands of residents and their families who are suffering today from neglect and care that fails to meet national minimum standards. Most progress in regulatory reform, however important, does not answer the problems of today's residents. The consumer sense of urgency for change is well-founded and grounded in the reality that regulatory change is always painfully slow.

It has been NCCNHR's privilege to present testimony, information and ideas to many outstanding senators who have actively supported nursing home reform since 1978. We applaud Senator Grassley's determination to hold the Health Care Financing Administration and the nursing home industry accountable to the public.

Because we have monitored regulatory activities of the Health Care Financing Administration for almost 25 years, we've seen a lot of initiatives come and go. Regardless of serious questions still remaining about how successful the present Initiative will be, we can say positively that we've never seen any initiative tackled by federal regulatory staff with such enthusiasm, even in the face of a small staff, determined by budget considerations. Although we have and will continue to be critical of some of HCFA's misguided activities, we have the utmost respect for the efforts of Nancy Ann DeParle, HCFA Administrator, and many of her staff members. DeParle, unlike most previous Administrators, has been exemplary in her outreach and willingness to listen directly to consumer views.

NCCNHR and other consumer groups are usually critical of government agencies because they move far too slowly. However, we have recognized since last summer that some of the serious problems and questions raised about and by the Initiatives surfaced because HCFA moved forward, sometimes beyond their control, too quickly. Soon after the July 1998 hearing and the President's Initiative was announced, important time should have been set aside for direct discussion and planning by all interested parties about what activities should be conducted that would make the fastest and most solid difference for residents. The nursing home system is entrenched; systemic problems do not change overnight.

NCCNHR's evaluation of the state of nursing home conditions and the 1998-99 Nursing Home Initiatives comes from several sources. Most importantly, we listen carefully to hundreds of family members, residents, consumer advocates and nursing home staff who have direct experience with both receiving and giving nursing home care.

We talk to state regulatory agencies and incorporate their reaction and ideas. And, we are in regular contact with staff at the Health Care Financing Administration charged with the responsibility of implementing and overseeing the Initiatives.

Although NCCNHR has strong questions about the future outcome of the Initiatives, it is essential for everyone to acknowledge that it's too soon to tell for sure what lasting and widespread effect they will have on the actual care and services received by residents. For this reason, the Health Care Financing Administration simply must continue to apply extensive staff resources towards the Initiatives. HCFA also needs much stronger coordination of the Initiatives and any future endeavors.

To achieve this oversight and coordination, NCCNHR recommends that a highly-qualified person, experienced with nursing home issues, be appointed to serve as a special adjunct to DeParle, working exclusively to oversee the Initiatives.

Furthermore, NCCNHR contends that stronger, week-to-week oversight of HCFA activities is in order to see that this Initiative doesn't slip and that implementation actually results in changes in nursing home conditions. **NCCNHR recommends** the appointment of a special task force at the Secretary's level, composed primarily of a qualified, experienced research team, as well as representatives from the Office of the Inspector General (OIG), the General Accounting Office, (GAO), and the Justice Department.

NCCNHR urges Congress to increase U.S. Dept. of Health and Human Services/HCFA funding to support these oversight activities as well as current and additional activities to strengthen enforcement.

Overall Stronger Enforcement is Still Critically Needed

A recent General Accounting Office report gives, yet again, a bleak picture of nursing home life. The GAO reports that one-fourth of the nation's nursing facilities (approximately 17,000) continue to have deficiencies causing actual harm to residents or placing them at risk of death or serious injury. This affects approximately 400,000 nursing home residents. If 40 percent of facilities continue to repeat their deficiencies, this affects as many as 160,000 residents. These numbers are staggering, and would be so even if there were far fewer residents affected. Based on direct day-to-day confrontation of serious problems, consumers and ombudsmen would argue that these numbers represent only the tip of the iceberg, because survey and enforcement programs are so weak. *(Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards, General Accounting Office, March, 1999)*

The Nursing Home Initiatives must continue, but must be bolstered by even stronger enforcement measures. Only then will we see the likelihood that protections and quality care directives in the national law will actually be achieved.

One of the most important pieces of the Initiative is still a mystery to consumers - the Federal Monitoring System (FMS). HCFA has reportedly completed 41.12 percent of 805 projected oversight surveys. We understand that there are 9 workgroups completing their tasks; however, consumers are eager to learn more detail about what HCFA is finding in the states. Consumer groups and ombudsman programs frequently report on the weakness of their state enforcement program. Even when serious deficiencies are found, enforcement action is missing.

The Regional Offices of HCFA offer another source of complaint from state agencies, surveyors, ombudsmen, and others. Although there are some good reports of strong oversight and enforcement positions by regional offices (such as Region II based in New York), many participants in and observers of the enforcement system find them often ineffective and obstructive. They are definitely considered inconsistent, as are the state agencies. **NCCNHR recommends** that a full study be conducted so that the effectiveness of the regional offices can be fully determined and needed changes made.

If the state agency always imposed quick remedies, this would be a strong deterrent to poor care in facilities. One of the impediments to this is the current Informal Dispute Resolution (IDR) process which was fought for and won by the industry, despite NCCNHR and other organized consumer protests. According to HCFA regulations, the states must offer facilities an opportunity to dispute cited deficiencies upon the providers receipt of the official survey report, HCFA-2567. If they request it, providers can refute cited deficiencies after any survey.

We were certain the industry and its attorneys would urge facilities to dispute deficiencies wholesale, and they have. If a provider is successful during the IDR process the deficiency citation can be deleted and any enforcement action(s) can be rescinded. Of course, residents, their families, and advocates are not allowed an opportunity to participate in, or to challenge this dispute, although the provider can have legal representation, which many do. Although a state may include ombudsman participation, it is not required.

Residents remain without supportive representation. The IDR process illustrates another reform needed in the enforcement system. **NCCNHR recommends that** Congress call for a study of the IDR by the General Accounting Office or Inspector General's Office to determine what explicit effect it has had on enforcement.

Furthermore, consumers seriously question that nursing homes can continually tie up enforcement proceedings through their numerous appeals. One of our consumer groups, Advocates for Nursing Home Reform in Austin, Texas, asked us to relay the proposal that nursing home provider appeals be limited. The serious shortage of administrative judges to quickly process appeals also continues and should be resolved.

NCCNHR agrees with Toby Edelman of the National Senior Citizens Law Center that the new draft of enforcement provisions in the State Operations Manual must be supported and fully implemented so that the federal enforcement system will undergo

needed improvements. Chapter 7 of the SOM contains instructions for imposing remedies on noncompliant nursing homes and includes enforcement consequences on States with inadequate survey performance. Though we are eager to get the regulations completed, we must admit that receiving a copy of the SOM from HCFA three days before the comments were due, last Friday, September 17, was disturbing. This blunder typifies bureaucratic delay that consumers often must deal with.

The bottom line is this: We now have better regulations on the books for aggressively pursuing enforcement in substandard facilities. Consumers are realistically and rightfully asking why enforcement is the exception, rather than the rule?

Staggering Survey Schedules

The one change we hear about most is that states are beginning to make some surprise visits during the night shifts and on weekends. We applaud this important effort, although it will need to be monitored carefully by HCFA. For example, I was recently told by a local ombudsman that in one state the surveyors began the survey at 4:00 in the afternoon and left the facility shortly after 5:00, counting that as their "evening tour." Also, consumers report that some states still view these initiatives as "advisory" and are not staggering survey schedules.

Still, we are gratified to learn of Nelson Baugh's good experience with his facility's survey in Georgia and reported this morning. We are also pleased to report another example from one of our Louisiana members who gives high praise for such a survey in her community. Mrs. Alan (Freddie) Pincus states in the attached copy of a letter to Nancy Ann DeParle:

> From January 19, 1999, through the 25th, a local team of surveyors plus two HCFA surveyors started an annual survey that usually occurs in June. They worked some evenings and through the weekend.....they missed very few of the egregious problems...

Ms. Pincus explained that this was a facility where the nurse call system had worked only intermittently since 1990. Linens had been in short supply since 1992. She had begun to think the "surveyors were blind."

NCCNHR and its members agree with the Pincus sentiment: "I sincerely hope this type of survey is not just a one-shot ray of hope for the residents." Although this survey change cannot be too popular with many state agency staff, it is essential for them to conduct such surprise "untimely" surveys so that the industry will have additional pressure to comply with standards – twenty-four hours a day, seven days a week. No doubt, the most serious problem for residents is the lack of nursing staff available to give care on evenings, nights and weekend shifts. Regrettably, frail, disabled and ill residents do not miraculously get better when the evening or weekend shifts begin.

Nursing assistants, particularly from unions such as the Service Employees International Union, continue to report that nursing homes somehow seem to know approximately when the survey is to be held. According to nursing assistants and family members, it is not unusual for a facility to hire extra staff only for a spell of time close to and during the survey. At a public meeting of union staff attended by NCCNHR in the fall of 1998, one nursing assistant stated, "the best 3 days of my working year are when the survey team is there, for I know that then we'll have the extra staff needed to care for all our residents." She was cheered by other assistants in the room.

One of our members recommends that survey teams need to come from another region where they do not know the management of the nursing home. In many areas, it is certain that nursing home surveyors and facility administration do become cozy over the years. Evidence of that fact is that so many surveyors retire or leave their jobs especially to go to work for the nursing home industry. Conversely surveyors may come from the industry.

Increased Sample Size for Nutrition, Dehydration and Pressure Sores

NCCNHR joins others in recommending that states be given sufficient survey budgets to increase the survey sample size. Survey teams should also consistently use valuable MDS information about residents to enhance their sampling process.

Sampling in the survey process is inevitable in a system with limited funding. However, one of the most serious dangers in sampling is that a single resident being gravely neglected and/or abused could be missed in the survey process. This is counter to one of the greatest protections promised by the National Nursing Home Reform Law, that "each resident," is to receive quality care, quality of life, and maintenance of individual rights. Dr. Andrew Kramer, University of Colorado, has testified to the importance of a larger sample twice before this committee. Consumers agree.

It is especially important for surveyors to be well-trained and always highly-motivated to identify those individual residents who may not be getting service. One of the best methods for achieving this goal, is that surveyors be particularly attentive to reports of day-to-day problems shared directly with them by residents, family members, ombudsman staff and volunteers, and citizen advocates familiar with the facility.

Complaint Investigations

Although we support HCFA's directive to the states to investigate any complaint alleging harm within 10 days, we understand that several states are resisting this measure because of the lack of staff resources to carry it out. In fact, one HCFA regional employee publicly stated at a Maryland State Nursing Home Task Force meeting, that HCFA has "backed off" of this initiative and is not requiring states to implement it.

The timely investigation of complaints is essential. We must determine as soon as possible how much an effective complaint investigation system actually costs, so that

HCFA's budgeting for the states will be sufficient and states can be held accountable. HCFA is supposed to be reviewing current state practices as well as planning to give funds to a private agency for a major resource project. In fact, work by NCCNHR is included in one of the proposals before HCFA.

For years there have been widespread reports of the failure of state licensure agencies to substantiate valid, serious complaints made by residents, family members, ombudsmen and others. HCFA simply must take advantage of consumer information about the dismal failure of most complaint investigation programs. For example, family members from Virginia and Connecticut report serious complaints of abuse and neglect that have been dismissed in the past year despite these Initiatives.

NCCNHR recommends that each state develop an active advisory group of residents, family members, consumer advocates and ombudsmen to assist it in improving its complaint investigation system. HCFA should do the same at the national level as they develop State Operations Manual (SOM) instructions on how to determine inadequate survey performance.

Private investigators working for nursing home lawyers are notoriously skillful at finding serious problems based on family reports of poor care. HCFA and the states should take greater advantage of such professionals by regularly involving them in surveyor training.

If more complaints were handled quickly and thoroughly with necessary changes made to resolve problems - giving consumers effective recourse for their grievances - family members would have fewer reasons to pursue legal help.

We are heartened that HCFA will be funding the study of the states' complaint investigation programs; however, there is an abundance of information available that should be utilized in immediate HCFA reforms. For example, the use of quality care indicators in complaint investigation should prove useful to survey agencies as well as ombudsmen, if the information is made available to them.

Propose Civil Money Penalties (CMPs) for "Each Instance"

NCCNHR, representing residents and consumers, has recently intervened in litigation filed in federal court by the American Health Care Association against the U.S. Dept. of Health and Human Services. AHCA challenges the per instance civil money penalty rule arguing that HCFA did not have statutory authority to promulgate a rule. Further, the industry challenges HCFA's authority to establish this additional remedy under any and all circumstances.

Surveyors report they are using this proposal, but only for serious violations, as they were taught in training. **NCCNHR recommends** use of per instance CMPs for less serious violations as a deterrent effect to continuing poor care. Advocates everywhere ask, "How can enforcement happen if CMPs are not actually applied and collected?"

Poor Performing Nursing Homes and Nursing Home Chains

We understand that the part of the State Operations Manual dealing with poor performing chains is still under development and not included in the latest September 1999 draft. Consumers and ombudsmen are adamant that something must be done to consistently identify serious problems and take action against corporate chains. A serious problem facing families and advocates is that they have to contend with corporate decision-makers sometimes many states removed from their communities.

NCCNHR supports the ability of HCFA to enhance oversight of poorly performing facilities at the "G" level. The June 30, 1999, General Accounting Office report *(HCFA Initiatives Improve Care but will Require Commitment)* gave ample evidence that surveyor citations were well-written and accurate, and showed that in 98% of their sample study, actual harm had occurred to one or more residents. HCFA should implement the expansion of the definition of poor performing facilities to include "G" level deficiencies that designate harm to one or more residents.

Criminal Background Checks and Worker Identification

Consumers have supported the initiative to require criminal background checks for all nursing home workers.

NCCNHR has endorsed the Kohl-Stark Patient Abuse Prevention Act. As now revised this proposed legislation would provide some due process for workers and also protect nursing home staff from bearing the cost of such checks. A National Abuse Registry, if implemented effectively and consistently, would address the issue of abusive workers crossing state lines.

One long-term advocate, Marie Wisdom from Advocates for Nursing Home Reform in Austin, Texas, recommends that every nursing home worker be required to wear a name tag which includes their picture, name, and thumb prints. She notes that government agencies, such as the IRS requires workers to wear them. Why not in nursing homes so residents, families, ombudsmen and others would always know who they are dealing with, whether the care is good or bad?

NCCNHR, the unions and others have been urging HCFA to require facilities to post the working staff roster on every shift so that families and residents will know who is there to care for them. This can also be used to determine the level of staffing on any given shift. **NCCNHR recommends** that the Senate Special Committee support this proposal.

Develop Better Management Information Systems

According to our discussions with researchers assisting HCFA with this Initiative, HCFA has not budgeted the necessary dollars to make sure that data systems are developed in a way that will assure that a quality assurance system will really work.

The MDS/QI System, a key to quality assurance, will also fail to support quality assurance unless HCFA creates an accurate, reliable, integrated data system.

HCFA needs to collect and report on information and results of the Informal Dispute Resolution system in each state; nursing home appeals and their results; and the number of citations assessed and collected. It is also essential for HCFA to provide information about the enhanced monitoring of special focus facilities, federal oversight surveys, and state complaint investigation findings. What did they learn and how can the information be applied to assure changes in the system?

Expenditures of public funds by industry should be more carefully monitored. A key is maintaining the integrity of the Medicare/Medicaid cost reports. The advent of the Prospective Payment System (PPS) threatens the very existence of cost reports for Medicare because payment is predetermined. However, since there are no prescriptions for how the money is spent under PPS, **NCCNHR recommends the following:**

> Require mandatory federal uniform cost reports for both Medicaid and Medicare with core elements and common definitions. States would be able to add on other elements as needed. This approach would allow HCFA, providers, and consumers to understand how money is spent and to compare the results with quality outcomes through the Minimum Data Set/Quality Indicator system.

Survey Information Available on the Internet

The provision of survey information through a HCFA website is a starting point, particularly for uninformed consumers. Still, knowledgeable consumers know that the survey information is only as good as the survey process and survey reports; therefore, **NCCNHR recommends** that this warning be given to consumers in a message up front in the survey report. Also, information is not put on the site in a timely manner, especially if the new survey information is replacing a deficiency-free report. In response to consumer complaint calls, NCCNHR regularly turns to the HCFA website to look at the survey results, often finding that they are over a year old. States must post survey information quickly after a survey, for we know that the quality of care can change quickly and dramatically, especially because of high staff turnover and frequent staffing changes. Nursing home care can be heavily affected, either to the good or the bad, by a change in any key member of the facility administration or a change in the number of staff.

1997 data contained in the 1999 American Health Care Association data book, divulges the following staff turnover rates: Administration, 21%; Director of Nursing, 32.5%; R.N., 50.6%; LPN, 51.3%; Certified Nursing Assistant, 93.3%; Department Heads, 32.9%. (Source: Buck Consultants Survey of managerial, Supervisory and Staff Positions in Nursing Homes, 1997.) An American Health Care Association staff member stated that they expect the 1998 and 1999 turnover rates to increase.

Since the 1980's we have advocated for HCFA to provide facility ownership information for consumers. Residents, their families, ombudsmen, advocates and others need to have specific addresses and telephone numbers of owners, individual and corporate, so that they can approach them to report serious care problems in facilities.

NCCNHR is pleased that HCFA will be conducting a pilot study using a NCCNHR postcard model to obtain evaluative information from people who visit nursing homes on a regular basis. Two states will provide residents, family members, staff, and other visitors the chance to complete a postcard check-off list to return postage-free to a designated agency. If this mechanism proves useful for consumers, it could provide valuable information to help identify facilities that may need to be looked at more closely. If adopted nationally, a system must be in place to support the use of this information.

Abuse Intervention Campaign

HCFA deployed considerable resources in this Campaign; however, some of the staff assigned to this effort were virtually inexperienced in nursing home care issues. NCCNHR contends that HCFA made its biggest mistake when it failed to call a group of all concerned parties together to plan a strategy, before initiating its own hurried plans. Time will tell whether or not the resources put into the new poster campaign will actually yield results. NCCNHR has advised HCFA since the beginning that the posters could be most valuable "out in the community." People can learn about ways to detect and report neglect and abuse before they use or visit a facility. We are still urging HCFA to use the posters in other sites such as senior centers, area agencies on aging, libraries, adult day care, hospice programs and public transport vehicles. It is our opinion that only good facilities will helpfully display the new posters. They will want to know if neglect or abuse is occurring.

It is good that HCFA has made revisions and is re-issuing its video and new written information to help consumers in their search for long term care. For sure, an educational campaign is only one small part of a larger picture of needed reforms, but these efforts are worthwhile.

HCFA is speaking the right words. Consumers can not quarrel with the motto HCFA has adopted in its new public education materials. "Enforcement assures quality; Education understands quality; and Empowerment demands quality." Although many of HCFA's Abuse Prevention Campaign materials are under an evaluation period before completion, they are useful and definitely reflect the public interest.

We know that this is the first time in history HCFA has actually attempted such a public endeavor. The consumer video, graphically presents a rosie picture not seen in most typical nursing homes, but it does state very strong language about HCFA's new stance to prevent, detect, and take action against abuse. It will be helpful, as accessible, to new nursing home consumers, and, if nothing else, will provide a tool for consumers to

help hold HCFA accountable for what it proudly and strongly claims it will *not do*: **HCFA claims it will no longer tolerate nursing home neglect and abuse.**

One thing is certain, the Campaign has caught the attention of the industry. For the first time, the for-profit industry has initiated a national game plan of its own against neglect and abuse, mailing all its members a set of materials on abuse prevention training developed and available years earlier by the Massachusetts industry association. Regardless of the fact that the American Health Care Association took a route (foolish in our opinion) of advising its members not to use the HCFA poster, the association has at least been forced to respond publicly to what our membership believes to be serious, widespread problems with abuse and neglect affecting thousands of residents. Industry always appears to act on the assumption that its image precedes good care. Consumers know that image follows good care.

Strengthening the Ombudsman Program and Advocacy Efforts

NCCNHR recommends that the Committee continue its efforts to reauthorize a strengthened ombudsman program, another one of the Presidents' Initiatives.

State and local ombudsmen are now being used by HCFA to provide input to the public education campaign. HCFA and ombudsmen have held discussions on major issues at the 1999 National State Long Term Care Ombudsman Training Conference. The poster project includes ombudsmen in ten states collecting information on how the posters are being utilized.

While ombudsmen, for the most part, want to carry out these responsibilities, it needs to be understood that every special project undertaken by an ombudsman takes time away from their day-to-day work with residents. It is this regular contact with residents that is essential to successful ombudsman efforts. The Presidential Initiative is one of the simpler initiatives to implement because there is a national ombudsman structure in place.

Three things are needed:

1) Reauthorization of the Older Americans Act including the current ombudsman language to continue the programs focus on resident and systemic advocacy; 2) substantial funding so that ombudsman programs in every state can meet the Institute of Medicine recommended requirements of one professional ombudsman per every 2,000 residents; and 3) a strong Ombudsman Resource Center that is able to meet ombudsman training, technical assistance and research needs.

NCCNHR calls on HCFA and Congress to find new ways to support and strengthen the involvement of family members and citizen advocates.

National Campaign to Increase Awareness on Prevention of Malnutrition & Dehydration

Malnutrition and dehydration are two of the many crucial and distressing issues in nursing home care. NCCNHR recognized this when we began our own campaign against malnutrition at our 1997 Annual Meeting with the keynote presentation made by Dr. Jeanie Kayser-Jones, a nurse anthropologist at the University of California, San Francisco.

It was during that meeting that NCCNHR successfully encouraged the Senate Special Committee to organize a pivotal forum on this topic. Dr. Kayser-Jones provided solid research findings that shows serious neglect of residents at mealtimes. This was followed by an alarming hearing on the extent of malnutrition and dehydration in California nursing homes – a discovery first made public by consumer advocate, Ila Swan, who has assisted this Committee in previous work.

Undernourishment remains a major, preventable problem; therefore, the work done by the Nutrition Screening Initiative and the American Dietetic Association is particularly valuable as a vehicle for public education. NCCNHR would like to see other professional groups step forward and lead similar efforts on substantial nursing home care issues. The complex problems in long-term care can best be identified with leadership and involvement by experts in particular areas, like what happened regarding nutrition. If caregivers work with HCFA from the beginning of program planning, they are more likely to be predisposed to implementing solutions. HCFA, instead of distributing the Nutrition Alerts is trying them out in ten states. The money for this could be better spent on implementation and support for a product already endorsed by all stakeholders.

This year, Dr. Kayser-Jones will return to the NCCNHR Annual Meeting to give the keynote presentation on dehydration. Her message, once again, is that staffing, especially the lack of it, is the root cause of this problem.

Since the issues of malnutrition and dehydration couple so directly with nursing home staffing, it is noteworthy that the Senate Committee on Aging is willing to help move this issue forward by hosting a forum on nursing home staffing during this year's NCCNHR annual meeting, November 3, 1999.

NCCNHR is pleased that the Administration heard consumer arguments against legislation allowing nutrition/hydration assistants. While NCCNHR understands the desire to take action to prevent malnutrition and dehydration, the lack of staff is a 24 hour problem, not just a mealtime problem.

Time and time again, when family members, residents, ombudsmen, advocates, workers and others are asked what is the most serious issue to tackle in nursing homes, **staffing is the answer.**

Dr. SCANLON. Thank you very much.

You can tell that the themes from everyone involve both powerful messages of what are unacceptable and intolerable situations. Some glimpse of progress is there but clearly this is a situation where we cannot rest on the progress that has been made. We need to think very strongly about how we are going to improve this situation even further.

I would like to address the first question to the three panelists who had a relative in the nursing home and who have thus connected in some respects to the system and the survey process. The issue is how did you find out about this process; how hard was that; and how different or alike do you feel relative to the other relatives of nursing home residents in terms of the availability of information; and finally what would you recommend?

This is a big question. What would you recommend that we do to make this an easier process for relatives of nursing home residents?

Mr. SUAREZ. OK. First of all, all I ever did was make a phone call. I made one phone call to the licensing bureau, and a 4-day investigation resulted.

Dr. SCANLON. I guess the question is how did you know to call the licensing bureau?

Mr. SUAREZ. OK. I knew someone in the Department of Aging. I said what should I do, and he said call the ombudsperson in Salisbury, MD, and I called the ombudsperson, and she said call the Licensing Department. So we are talking about a matter of one day, which brings me to the other question: How would I know if I did not know somebody at the Department of Aging? It would seem to me that maybe—I am reaching here maybe—that the State Department of Aging have all new residents who go into a nursing home, and that list must be supplied by the nursing home, and a packet comes to them saying when you have a problem, here is who you call.

It is like your magnet on your refrigerator. It is the quick and dirty list, and that is what you don't usually know, even though when my father went to a nursing home, they said there is somebody at the nursing home you could talk to. I had basically exhausted conversations with those people and had become somewhat of a nuisance.

So I guess really knowing who to call is important, and maybe my case is unusual because there was, within 1 month, a 3- or 4-day investigation.

Dr. SCANLON. Ms. Clayton.

Ms. CLAYTON. Well, my situation is a little bit similar, although it has been ongoing for quite a few years. I have contacted the State, and the State has come in and, you know, investigated complaints. I have reported problems, and they have been included in the complaint investigations on the next survey.

As far as family members knowing how to go about this, I do think the family members have a right to know, and I don't think they are informed very well. There is always the sign somewhere in most nursing homes of calling the 1–800 number for a hot line for abuse and neglect in the State, and that is about it. And I think there does need to be something, and I think his suggestion of ac-

tually sending out to family members for new residents might be a very good idea. I also think possibly even public service announcements, something like that, maybe newspaper, you know, advertisements, anything, because we need that protection for the residents, and the family members visiting are their eyes and ears.

Ms. LENHART. I don't fit in that category, but I would like to respond. When consumers call me, they usually already know about the hot lines to the ombudsmen and to the abuse hot line, and usually they have already called those places and have unsatisfactory responses, that is to say they don't ever hear anything, and in some cases they have no idea if an investigation ever occurs, because they are unable to visit the nursing home at the time when it may be occurring.

Most recently, though, I am getting calls from consumers who are keeping a close watch on the nursing home, sometimes because they are staff and are concerned about the number of nursing hours that are provided per resident, and what they are telling me now is that they do see the investigation happen. One or two surveyors are there for most of the day but they only talk to the administrator, the DON, and maybe one resident. Thus the investigation may occur, but it is not thorough. Then afterwards complainants don't hear about the results except for a form letter that may have one out of three boxes checked: substantiated unknown or unclear results or not substantiated.

So they don't get information to allow them to follow up. What I have been encouraging them to do now is to call and complain again that there hasn't been a thorough enough investigation.

Dr. SCANLON. OK. Mr. Korber, can you talk about your difficulties in finding out who to talk to?

Mr. KORBER. OK. Yes, as Ms. Clayton had mentioned, at the Beverly Enterprise Nursing Home, there is an 800 number that has been posted for how to get a hold of somebody from the State of Pennsylvania; however, that is about the extent of what is there, and in the past, certainly as I had talked to different family members who had reached out that way, the State of Pennsylvania, until fairly recently, had not been very responsive to those sorts of things.

People had been dissatisfied with the results, and one of the reasons I hadn't reached out to the State earlier is when my mother was first admitted to the nursing home, the administration there had said, "Hey, if there are problems, we would like you to work with us directly. Don't bring in outside third parties. Work with us. We will try to resolve your issues." And I believed in that and worked with that for basically the last 8 years, and I am at where I am at today, and when I reached out, I am glad to see that the State of Pennsylvania has changed its approach to some of the things here in terms of surveys and how they respond to complaints.

Dr. SCANLON. Now, a source of information is the HCFA website that lists the results of surveys. Were you able to use that, information and even further, what do you think would be useful in terms of changing the information that is on the website to make it more useful? I guess, again, think about how you relate your ex-

periences to that of the typical family member of a nursing home in terms of awareness of the site HCFA.

Ms. CLAYTON. The HCFA website, as far as—I want to say this about all of the websites right now that have to do—from an advocates point of view that have to do with giving you information. The information is generally old, behind, not detailed enough, and when you stop and think that it is based on the latest survey report, the problem is that so many of the things that go wrong in the surveys are dropped, edited, so that the final survey that gets there, you kind of wonder, well, gee, how many pages and what was wrong in the first one and how many things happened to them and how many things were dropped off.

You don't know how often, how many. It doesn't tell you about the complaints. It doesn't tell you how many complaints in between. You know, define and revisit, it gets very complicated, and the average person out there is under stress from their doctor, told you have got to place this person in no time at all.

Now, a lot of us have computers, but there is a generation out there that really doesn't. How are they going to get this information and decipher it and since it is incomplete and it is old. So I think it is great to have it out there, but it needs to be out there sooner, faster, better, and the world needs to be aware that it is available.

I still think the print and the TV media, so on and so forth, should be used to let people know.

Mr. SUAREZ. I wasn't aware of the website, but, obviously, my father had been tested at Johns Hopkins and been in a program before he went to a nursing home, and they said you are going to have to be very, very, very aggressive in the nursing home to not know about the website.

But my experiences are very similar to other residents in the nursing home, and just to relate one quick story, my father's roommate was a doctor who was at that facility, and his wife was very aggressive and still experienced the same discomforts and problems that my father did. So if the wife of a former doctor at the facility was not listened to, it really—it indicates the depth of disregard of patient complaints, and you have to go to a higher level.

Dr. SCANLON. I have a question for our two ombudsmen. It is about your experience in working with resident counsels and other volunteer advocates and whether they are able to solve problems at the facility, or does it require someone with authority and the potential to impose sanctions to correct problems within facilities.

Ms. MEYERS. I will go first. To answer the last part of your question, truly, resolution depends entirely on the administrator, administrative staff, on whether or not they want resolution, whether or not they are willing to work with you. We provide our volunteers with very specific tips and guidance about how to approach staff, when to approach them, how to craft your complaint, being very specific about your complaint, as descriptive as possible.

So it is a member of our resident advocate group. We are very specific on training them about how to approach the staff, but ultimately whether it is families or whether it is the volunteers, it depends on whether or not that administrator wants to work with you, and if they don't, if that is their choice, and you have done

everything you can as far as trying to build that relationship and make it work, if they don't choose to be part of that process, then you do need to go to the regulatory process; and we don't very often find resolution there either, but at least it is another avenue for us to use.

Mr. MILLER. I would just simply reiterate that. A lot goes back to how supportive the facility administration is with their resident council. Unfortunately, I think it is a mixed bag out there at this point.

Dr. SCANLON. Another question that follows up on this point is whether the ombudsmen could benefit from having additional authorities or powers that would facilitate their effectiveness. Anybody else that wants to comment on this, please do as well.

Would you like to take a stab at that? Did you plant this question?

Ms. MEYERS. Funny you should mention that. What types of additional controls?

Dr. SCANLON. Powers or authorities that they might have to carry out their functions. I mean essentially to give them leverage in the negotiation process.

Ms. MEYERS. Well, in Iowa, we certainly have pretty good luck as far as access to records and that kind of thing. Obviously, we would love to have more access to the investigations that are done by the regulatory agency. We don't have access to see how they made their determinations, how they determined compliance or noncompliance. So it leaves us kind of empty-handed because part of our function is oversight or working with the regulatory agency, but we don't have any access to the information on how they conduct their business. So it is difficult for us from that standpoint to be able to do much to intervene on that process.

As far as control, I mean, obviously we would love to have that great, big, huge hammer that would force compliance, but I am not sure—you know I am just not sure other than to be able to mandate that thou shalt do this. I don't know that there is a hammer big enough for that.

Mr. MILLER. I am not sure that it is a question of additional authority. Part of it goes to what Debi had mentioned, the ability to coordinate and get information from the survey agency and other agencies that oversee nursing home care.

That is kind of one issue, but the other is how independent the State ombudsman office gets to be and whether or not they can actually address some of the larger systems issues. When you are in the system, it can oftentimes be difficult to criticize that system from within, and so a lot of it has to do with where the State ombudsman office is, I think, located and how much independence they are given by their State unit on aging.

Ms. HOLDER. Dr. Scanlon.

Dr. SCANLON. Sure.

Ms. HOLDER. In the Institute of Medicine study that was done on the ombudsman program, one of the major recommendations was that there be a paid ombudsman for at least every 2,000 residents in a facility, and I believe that should be supported by Congress with funding. Although we say we have a nationwide ombudsman program, we know that it varies in strength across the country,

and we know that they can't do all their work without people working to help train and monitor the volunteers. So certainly additional funding is very warranted.

Ms. CLAYTON. I am from Missouri, and I have actually taken the ombudsman program training course. I am not an ombudsman, but I took it. I was interested in taking it because I had heard that ombudsmen were not allowed in Missouri to hot line instances, things they saw in nursing homes. I took the course. I found out that is true. As a matter of fact, I have the manual at home that says that in it in about three different places. You are not to hot line. You are not to call the State directly. You are, instead, to wait until you get back and talk to your regional ombudsman person.

I am talking about the volunteers that work in nursing homes. I think that they need to have that power when they see something. I don't think it needs to be secondhand. I think we need to get it to the State as quickly as possible. As I say, when you are a resident, and you are sitting there wet, somebody needs to know about it, and to negotiate and talk about it for a couple of days and decide what to do, you are sitting there in pain, and it isn't very comfortable.

So I think they need to be—to have that opportunity, and as far as always discussing and going over every single thing with their regional coordinator and waiting and processing all that through, I think that is a little bit of time that sometimes hurts the residents. So I would like to see that changed.

Dr. SCANLON. Ms. Holder raised the issue of resources, and it comes up in a variety of contexts. We have a question about the idea of targeting resources. Surveyors have suggested, that given the constraints on them, could we target the surveys on core facilities and put fewer resources into the best facilities. Would this improve things overall?

Ms. HOLDER. Well, nursing homes are paid to do what they do. I mean they get into the business and know what they are doing when they get into it. So I think there should be a close look at how nursing homes manage their money, how they spend them. As you know, historically we have talked about the high cost of poor care, and we know that because nursing homes understaff and do not provide the services that are needed, particularly under Medicaid, that that means that people deteriorate and often even die unnecessarily and prematurely because there is not good care.

The person who is not cared for who becomes dehydrated, has pneumonia and these other conditions ends up in a hospital. Then it costs the taxpayer more and more dollars because of that money. Then the person goes back from the hospital, into the nursing home, once again gets poor care. So the yo-yo back and forth from the hospital.

There is a tremendous amount of money in the system that is being spent very poorly and actually criminally in my mind that needs to be looked at to find more resources.

Dr. SCANLON. I think that also, I mean, deals with another question which is the question whether Medicaid—we feel Medicaid needs to pay more for nursing home care in order to assure quality, and I guess all of your experiences in that regard are relevant.

Ms. CLAYTON. I don't know. The money they are spending now on it doesn't seem to indicate, according to all the noncompliance nursing homes around the country and the lawsuits and the horrendous stories in the newspapers and so on, that they are getting it now. Why can't—I mean any increased dollars should be tied absolutely directly, verifiably to direct care staff increase and to the quality of care issues that should be monitorable by the MDS computer information that is submitted by the nursing home, and I think that needs to be reviewed and reviewed on a no longer than a 6-month basis.

I mean, if you aren't doing well in your last State survey, and if your number of decubitus ulcers are increasing, and your residents' abilities are decreasing, and you have urinary tract infections, and so on and so forth, I don't think you should get more money. As a matter of fact, I think they should be penalized the opposite direction so that the additional funds are available for the few nursing homes that might be willing to actually improve their care.

Dr. SCANLON. Well, has anybody from the financial side seen situations where you feel that there just are not enough resources to support adequate care?

Ms. HOLDER. Dr. Scanlon, I just would say that although we talk a lot about poor nursing homes, and they are widespread across the country, we know there are good nursing homes which do operate under the Medicaid dollar and do provide good services. I think consumers are very reluctant to ask for more money for an industry which is responding to patient needs so poorly.

Dr. SCANLON. OK.

Ms. MEYERS. I think in Iowa we have one of the lowest Medicaid reimbursement rates in the State. So that is used by the industry as an indicator that the Medicaid rate must be raised, but we also have some of the lowest costs in the country, and we also have some of the lowest acuity rates in the country. So the message that we are carrying into session this time around and that we are really preaching big is that no matter what your funding mechanism or your reimbursement strategy, if there isn't a component in it that is strictly based on quality and on performance, then you are just continuing to throw your money into the same pool.

We have had over a 40 percent increase in our Medicaid rate over the past 5 years in Iowa, and I can't say that there is going to be anybody in that State that is going to step forward and say that the quality of care and the quality of life in our facilities has improved that kind of a corresponding amount. We have a mechanism in our Medicaid reimbursement structure right now that could be budget neutral that could provide an incentive to those facilities that are good performances and a disincentive to those who are poor performers.

So, again, our message is whatever reimbursement strategy you want to entail, and we strongly support any kind of additional funding for our elderly in the State, be it community based or a facility, whatever mechanism you put in place, there has got to be some kind of a performance measure in place so that we can reimburse at least part on performance.

Mr. MILLER. There seems to be, a theory in the provider industry that the higher the reimbursement, the higher the quality of care. I think from some of the stories we have heard here today and the analysis that we have done in Virginia you just can't draw that conclusion.

You can get just as poor quality care in a facility where you are paying privately at four or five thousand dollars a month as you can in a facility that has all Medicaid reimbursed care. To some extent resources impact quality but not to point that I think the industry in this country would like us to believe. It just doesn't work that way.

Ms. MEYERS. What we have said is that the industry will always complain about the four Rs—I mean about the three Rs: reimbursement, regulation, and reporters. And I think they will always complain about those issues.

Dr. SCANLON. OK. One of the parts of the initiative has been described today. We have potentially raised the bar for both nursing homes and for State survey agencies. Toby, I think you probably have got the most familiarity with the relationship between the Federal Government and the States and the contract that they have for doing the surveys.

Federal surveys are used to assess the State surveyor's performance. The question is what is your view in terms of the effectiveness of those look behind surveys either currently or in the future in terms of being able to measure surveyor performance so that we can hold state agencies accountable.

Ms. EDELMAN. That is a hard question to answer. I think we have heard from advocates in New York that when the regional office took a strong stand about noncompliance in facilities and started imposing remedies directly, it has made a difference in New York. The State is turning around to some extent, but I think the big issue is not just writing down deficiencies—because we seem to be very fixated on that as if having deficiency is the end of the line, and it is only a point that if something happens as a result—and I think what the GAO report talked about in July 1998, having 99 percent of facilities with deficiencies given a chance to correct, means that the system doesn't work.

The Federal and State relationship I think is something that HCFA is trying to work on because there is not very much connection. The central office doesn't even have any control over what the regional office is doing. They seem to be scattered in how they oversee State performance. Some seem very knowledgeable. Some seem to do nothing at all. I mean, one regional office told me at one point that when they looked at how their predecessors handled their look-behind authority, they saw that the Federal surveyors went just to their immediate geographic area, not to the entire State, which is, you know, preposterous as a way of doing any kind of oversight.

So I think that is an area that really needs a lot of attention and hasn't had very much attention at all.

Dr. SCANLON. Anybody else?

Another thing that has come up a number of times in your statements was the issue of staffing and the idea that we need some minimum staffing levels, and while it is an intuitively appealing

idea, there are questions of how we go about doing—developing these standards well and then ensuring that they are complied with, and in part because we have a significant diversity of nursing homes, that they are all not dealing with the residents having the same kinds of needs, and so that is an aspect of this. So that is open to anyone that would like to comment.

Ms. HOLDER. I think that is a cop out. Certainly every nursing home has people of varying different degrees of needs, but the fact is there are a lot of people who live in those facilities who have tremendous needs, and we have heard stories this morning where people don't get even basic needs met. There is no question in the consumer's mind that there has to be more staff, and we know that just bodies aren't everything.

I mean, we are not dumb. We know that workers need good training. It takes good supervision. It takes good motivation, everything it takes in any human endeavor. But the bodies have to be there first. I think that certainly NCCNHR's proposed staffing standard is a place to start, and in fact work has started. There are about 30 States that are looking at minimum staffing standards, at least looking at the issue and talking about it obviously for the first time.

We see very small progress. It is a small step, but it is more than we have seen in the past. So I think that people in Congress have to listen, and HCFA has to listen. We are waiting for the Abt study, as you know, the Abt study on staffing standards. Everybody is using that study as an excuse not to do anything. The Abt study has to be completed. Hopefully it will come out soon. It should have been last spring, but now maybe it will be this spring.

The fact that this Senate committee is having a forum on staffing at our annual meeting this year is significant. So people are starting to listen, but they have to listen carefully to what consumers are saying, not what the industry is saying, about staffing.

Dr. SCANLON. Could you briefly describe your proposal?

Ms. HOLDER. Sarah Burger, who is here, could describe that for you in terms of the numbers. I am poor on numbers on the spot. We do have a minimum staffing standard.

Sarah, can you? Talk about putting on the spot.

Dr. SCANLON. Just in general terms. Would you mind coming to a microphone?

Ms. Burger. The basic building block is for direct care staff, that is those who are doing the work with each resident, and that would be CNAs, for the most part, although it could also be RNs and LPNs if they happen to be doing that kind of work, which is rare. That is a ratio of 1 to 5 during the day, 1 to 10 in the evening, 1 to 15 at night. And I have to tell you we have lots of criticism, particularly about the 1 to 10 in the evening, because that, too, is a very busy, busy time, and it has often been suggested that that ought to be nearer to daytime.

One other issue, as long as we have mentioned it today, is the issue of who is there to feed residents, Dr. Jeanie Kaysen-Jones' work at the University of California who presented at a forum before Senator Grassley. She has recommended that there be—for those who need complete assistance to eat, a ratio of 1 to 2 or 3. So that is an additional piece which has to be in place.

Ms. CLAYTON. I would like to say that not only do I totally support NCCNHR's staffing, I would love to see it in all nursing homes in the country, but I also think that needs to be considered as a minimum. And many homes do have residents with more acute needs, and the States still need to be able to—if they can document the things involved in quality of care, they still need to be able to cite for under staffing even if a nursing home has the minimum number.

In other words, that is just a minimum. If you have got sicker people and your facility needs more people, you should not be able to get by with just having that minimum number and, again, adding on for people who need assistance in feeding because feeding is so critical. That is what bedsores, all your problems come from, part of it, skin breakdown, nutrition, and it is so critical, as well as choking and so on, that staff needs to be added in this too.

Mr. SUAREZ. Here is the other thing I noticed, because I deal with staffing in the real world in education. There is extremely high turnover in the staff. The turnover—because I felt like I could train the staff myself because I was there so much, if they would just stay, but the turnover was incredible. When I called the ombudsperson, she said she had had several complaints about the turnover, and now whether the turnover is a supervisory problem or a salary problem, whatever, but in the Alzheimer's unit, I dealt with extremely high turnover, and these are the people who actually need the most specific care because they are so idiosyncratic in their issues.

So I don't know where that comes in in terms of is there a trigger that would show up in reports, whether there it was turnover issue, and, you know, you are going to have the other issues there also.

Ms. CLAYTON. I think better pay and more training for the aides might help that. A few more benefits will cut down on turnover and therefore help the residents.

Ms. HOLDER. Also, in my written testimony, I have figures about the turnover rates in nursing home staff all the way from the administrator to the DON to other people. It is alarmingly high for every sector of the nursing home. So even if you had a stable staff of nursing assistants, you would still have a lot of problem with staffing if there is other key staff turn over, all the time.

Ms. MEYERS. We did the—there is an agency or organization in the State that is comprised of certified nurse aides. It is their representative organization, and they did a survey this year and talked about turnover and asked them why and that sort of thing, and of course money is an issue, but the real issue that kept going through all the results and through everything else is the support, the attitude of the administrator, the DON, their supervisor. It is how they treat their staff, and that is not something that you need money to do. It is giving them—doing support groups, working out flexible scheduling to accommodate day care, stuff that the facility itself could do to manage that turnover.

I know that we talk about the need for additional staff as a monetary issue, but, again, I look back to the facilities and say the CNAs themselves are saying we need support. We need encouragement, just a pat on the back, the simple kinds of things that we

all—you know, that we all look for in our job, and I can tell you I was a CNA years ago. I don't remember the day I got a rate increase, but I do remember the day the administrator knew my name and told me that a family had said something positive about me, and that is the kind of stuff that they are looking for, just like all the rest of us, and if you have a facility where the administrative staff doesn't do that kind of thing, you are going to have turnover of your CNAs, and you are also going to have poor quality of care, I am sure.

Ms. EDELMAN. I think there are things that—I am sorry.

Mr. KORBER. Go ahead.

Ms. EDELMAN. I think there are things that HCFA could do about this right now. The new protocol that went into effect July 1st, the new survey protocol, has a special section on nurse staffing, but that is only used if somebody decides there is a problem with nurse staffing.

I think they should use that in every single survey. Evaluate the staffing because it is such an issue that everybody recognizes should be a definite part of every single survey, and HCFA should give guidance to State survey agencies to use directed plan of correction, one of the authorized remedies to say if the survey team finds there is not adequate staffing, give a plan of correction that requires the facility to hire staff.

I mean, I think the tools are there if there was some will and direction to use them. Not that it shouldn't be better, and we shouldn't have minimums, but we have things that we could do even now. We don't have to keep waiting for this report that is going to come out sometime.

Dr. SCANLON. This is a question that deals with a specific instance, but it also raises the larger issues in terms of the coordination between ombudsmen and advocates and survey agencies. The question is: A few months ago, a resident of a nursing home in Virginia sent a written complaint to the State licensing agency complaining that there was no one available to remove her from the toilet for over 2 hours. The home's recent survey did not even interview the complainant nor has the complaint been responded to in any way. The State agency did not even pull the staff records for the day in question to investigate.

Even though this complaint went to the State agency, the issue here is that ombudsmen and advocates have information about the case that surveyors could use before the survey begins.

Anybody?

Mr. MILLER. I guess since it was in Virginia, I will try to respond to that, although I certainly can't respond for the survey agency. I think it is a case in point of the one-way flow of information which sometimes happens. You don't hear anything back.

Oftentimes local ombudsmen have complained to me that they have gone into a nursing home, verified a complaint issue, tried to effect a resolution, and have sent this information on to the Health Department for their follow up. Unfortunately it might be many months later before they ever show up. By then the people that were providing the care are gone, and it is difficult to put the record back together to find out what happened. So the follow up is not as effective.

In talking with the survey agency director, it is simply a matter of resources. They may think that if an ombudsman has been in a facility, and attempted to address the complaint there is less of a need for them to do an immediate follow up, which is not always the case because there may need to be a larger corrective action. We may have fixed it for one resident, but that same problem may also be impacting, dozens of other residents, and that is where we need the State survey agency to investigate and take action.

Without being overly critical of our survey agency, there is to some extent a one-way flow of information at this point in terms of information going to them but information not coming back.

Ms. CLAYTON. That is why I had said about the more in-depth, was because currently both in the complaint information manual and the survey manual they are supposed to, the surveyors, review the history of the facility and information about the residents and the MDSs and so on before they pick their statistical grouping, their sampling of residents plus a couple of extras in case a few people have died. They then show up.

That sampling is not enough. There needs to be more. They need to spend longer. They need to put more time and effort into going through the books and the records and so on and so forth. The survey just has to be more in-depth, and the complaint investigations have to be more prompt and far more in-depth and a greater number of staff and so and always photographing and so on and so forth.

Mr. MILLER. If I could just add a couple of points to that, in Virginia we find out about the survey process in the afternoon of the first day the surveyors are there. So it is often difficult for local ombudsmen to then participate in the survey process or to get to the facility and talk with the residents they have talked with or contact families to say the survey agency is onsite, you know, this is your opportunity to go and speak with them.

And so it has to do with advance notice, and I have an example just this week where a resident called me on Tuesday morning and had a complaint, and then, finally, on Tuesday afternoon, I realized, well, the survey agency was literally at the facility right at that point. Had I had some advance notice that they were going there, I could have told this particular family member that that opportunity was going to be available, and unfortunately this family member lived quite a distance from the nursing facility where her mother was.

Dr. SCANLON. There has been discussion or reports lately in the media about an issue of putting in hidden cameras to monitor the care that residents receive, and it has been discussed in terms of both the benefits that may ensue as well as some of the issues with respect to privacy and residents' rights that are also involved.

I would ask any of the panelists if they would like to comment on these ideas which have led, in a number of States, to legislative proposals. We have instances where the cameras are being used.

Ms. CLAYTON. I think the opposition, the strongest that I heard was, what, September 12, just a couple of days ago. It was the American Health Care Association's concern over the residents' privacy and so on.

I, too, am dealing with the Beverly facility. I am not saying—I have dealt with quite a few, but it seems to me like nursing homes are suddenly very concerned about something that I walk up and down halls all the time and see, curtains open and naked people and so on and so forth in there all the time. So somehow that doesn't—these films would be taken by the legal representative by the family of the resident. They would be limited to that resident's room, to that one resident, and they would only be viewed by those people.

I can't imagine the situation wouldn't be bad before a family would be willing to do this and would investigate. It is a rather expensive proposition, so I don't think very many people are going to be doing it. If you are not doing something wrong, I don't think you mind too much having pictures taken.

Mr. KORBER. Let me echo that because I can tell you in the 10 years my mother has been in a nursing home, I have probably seen several hundred people that have been through that facility, and there are people that sit in the hallways naked. There are people that you can walk down the hallway and see just about anything you would want to see. So the issue of privacy is a cop out, I think that is the term I have heard.

Ms. HOLDER. Certainly, every family member who wants to have a camera should be able to have them. I mean that should be an individual right that should be worked out with the facility.

I have an impression of what you would see. If the cameras are on 24 hours a day, probably the best of what people could see and truly monitor would be that there would not be much care going on at all in a lot of those rooms. That would be probably just as important to see the neglect as well as any abuse.

Ms. EDELMAN. I think the problem with it—I mean I agree with Elma that if people want to do it, and it is also the resident's concern, it is OK, but, I mean, to what end? People can't watch a camera 24 hours a day, and if things are done—I mean I think it is putting the burden on families to say you are responsible for monitoring care because none of our public systems work.

So it is a useful thing. It might help. It might get some information, but we can't have all of our hope as having this as the answer for people, because I think it just puts the responsibility on them instead of saying the public agencies or the facility have responsibility. So I am troubled by this, and I don't think it necessarily is going to do what people think.

This happened a couple of years ago in Texas where the family videotaped what was going on in the room and you could watch it. It was on television. The aide threw the resident, spoke very sharply to her. This was shown to the State agency, and the State agency said, well, we don't think it was the facility's fault. It was the individual aide. So nothing happened. Even having it documented didn't lead to any kind of public response.

So this is not the panacea if people are hoping it is a panacea.

Dr. SCANLON. The general tenor of everything that we have discussed is, of course, that we need to do more. Yet there have been reports and stories that in some respects the system is somewhat too vigilant in that it actually facilitates small violations. Some of these reports relate to these facilities being on a termination track,

so that they may ultimately be barred from Medicare and Medicaid because they have a D-level deficiency.

The question would be—Toby, again since you know this process, I will ask you to start. Could you comment on that, as well as perhaps for the audience's sake describe what a D-level deficiency is?

Ms. EDELMAN. D is supposed to be isolated, no harm.

I don't think we can say the system is too vigilant. I mean, I can't imagine how that term could be used with respect to the nursing home enforcement system. I think the problem that is going on with the terminations is that the Federal Government was trying to say it was going to take a strong stand when there were deficiencies, and if deficiencies were not completely eliminated, if there was anything at the D level or above—so anything more than substantial compliance—after 180 days, then the facility would be terminated.

I think termination really is a terrible thing in most situations for the residents and their families. These cases are very devastating. I think the problem is that there is no enforcement that goes on during that 6-month period. The typical cases have the same pattern where the survey team comes in; sees serious deficiency, sometimes immediate jeopardy, but serious problems; writes down deficiencies; goes back repeatedly, four, five times during this 6-month period; and the facility, to some extent, comes into compliance.

But then the 6-month period ends, and the State says we are terminating you, and then the facility goes to court and says we are representing our residents. Transfer trauma, this is really terrible to hurt our residents, how can you do this. And the entire atmosphere changes, and families that have been calling for help and change then get very angry with the Government, and justifiably, for terminating the facility.

So I think to me what the reform law was supposed to do in the enforcement part was have a response quickly when the problem was identified so that the problems were fixed for the people right away and the facility maintained compliance, and if that had happened, and if the deficiencies would be taken seriously from the beginning and responded to, we wouldn't get to this 6-month period.

Ms. CLAYTON. They worry so much about a D. My father's was a G, isolated, actual harm. The three Category One penalties that could have been imposed of course included denial of Medicare, Medicaid payments, the denial of payments, and $50 to $3,000 a day, I believe, penalties.

None of those were imposed. They chose instead to pick one from the Category Two. They had a, I believe, about a half hour's worth of in-service training again on how to appropriately use a shower chair. That was it. So it is a lot more than the little alphabet there.

Ms. EDELMAN. But I think, Dr. Scanlon, the GAO report said that certainly the G-level deficiencies, when that report was issued at the hearing in June and you testified that 98 percent of the deficiencies you agreed with, that they were very serious problems, they were harm; and when Senator Grassley asked you about the discrepancies among States, that some States cited a lot and some States cited few, your response was that the GAO hadn't found any more disagreement with facilities that cited a lot, which led the

GAO to conclude, if anything, that States were much too tolerant and should be citing more deficiencies, probably at a higher level.

So I don't think that the deficiencies are generally nit-picking things, although, I mean, we have all seen some stupid deficiencies, but basically they are citing very serious issues and nothing happens, and that is the concern.

Dr. SCANLON. That is correct. We looked at a random sample of G-level deficiencies. In analyzing them we found that they really were serious cases of actual harm to residents.

The issue, I think, is what kind of a sanction is then imposed? As you pointed out at the very beginning of your response, it is the 180 days of being out of compliance that is actually what triggers the termination track as opposed to the specific level of an individual deficiency. We have a very different picture here than just saying it is a D-level deficiency.

Ms. EDELMAN. But it does make the survey agency look somewhat foolish to be terminating a facility and moving hundreds of people to places that may be worse and may be far away and families can't visit when the deficiencies are considered so trivial even to the State agency, although some of those things are probably not trivial at all. We would call them harm.

I mean, this deficiency that the Nevada survey team found for staffing, the inadequate staffing in the midnight survey that I started with, they cited that as F, which is widespread but not harm. I don't see how that could be a no-harm deficiency if there is not enough staff and people are suffering bad consequences.

So there is a lot of gaming that goes on with the coding of these deficiencies, and I think States want to call them low-level deficiencies so they don't have to take more action. I mean, not that they don't want to, but the entire system is focused on making it very difficult for States to take action.

There is informal dispute resolution which the providers can use. There is no opportunity for families to say we told you about all these problems, where is the deficiency. The whole system is only to remove deficiencies, to respond to the provider that is complaining about it.

Ms. HOLDER. Mr. Scanlon, I think that one of the most important studies that could happen, and is supposed to happen, is the study of complaint investigation and what happens to complaints. I think consumers could argue, just as the industry argues that licensure agencies are too vigilant, that all these complaints that are in the system—hundreds around the country—don't turn into deficiencies at all. I think that this study is going to be one of the most helpful—if they really look at what happens.

I know that even in the court systems now you find attorneys who are obtaining major victories over things that happen to residents. They are able to find harm that actually happened but a deficiency was never cited. At one time a family member may have been satisfied with a deficiency finding and correction, rather than lawsuit.

Ms. EDELMAN. Well, I think Elma is absolutely right about that. I got a call from a granddaughter whose grandmother was given her roommate's medication. It was a drug that she was very allergic to, and she had a terrible reaction and was sent to the hospital,

and the granddaughter thought her grandmother never really recovered from it.

The nurse who gave the wrong medication wrote an incident report. She said, I gave this woman her roommate's medication. She wrote on incident report. The granddaughter filed a complaint, and it came back not substantiated.

I mean, there was an incident report with an admission, and the State said that this was not a substantiated complaint, and the granddaughter was going to appeal it and then got so frustrated that she decided to pursue a tort case because she just felt what Elma has said, that, you know, she is not getting any satisfaction out of the regulatory system. It is not providing protection to her. She thought she would just sue. She was so angry about how she had been treated, how her grandmother had been treated especially, but you know, the system had not responded to this complaint which was obviously true.

Dr. SCANLON. Let me ask one last question, and I direct it primarily to the family members but also to the rest of the panel. What is the message that you would want to come away from here for other family members in terms of what to look for in a facility when they have a family member that is going to become a resident.

Mr. SUAREZ. Well, I think what I mentioned before, that you would be told by some agency when you come in the things you should check for for your relatives, your family members, the dehydration, check the logs in the nursing home—which I had to be aggressive about—when something was—when you were there, and they said we have ordered this and it doesn't happen until three or 4 days later, and this was a constant thing in my situation.

Now, amazingly, this was all recorded. If it hadn't been recorded, they would never had been able to catch it, but, you know, you were there, you saw the logs, you also ask to see the feeding charts every day as to what percent of intake there was, and that is why I decided to hire a caregiver.

But, I mean, somehow that checklist has got to get to the families of the new admissions into the nursing homes, and I am just not sure that the materials I received from the nursing home really—either they were too voluminous, or they just didn't point it out, and so there has to be some way to point you to look for those things so that you can be very specific in your complaints either to the nursing home or to the ombudsman, because the specificity of my complaints supposedly is what led to some pretty stiff, you know, penalties here in this case.

Ms. CLAYTON. I guess mine would be to family members is not only to look out for your family member, which you are going to have to do, but apathy. I mean care about what is going on for the other family members, care about it as far as legislation. If you have a certificate of need situation in your State which limits competition and building other nursing homes in your area, care. You know, contact your legislators. That is the only way that they are going to know that people out there are actually going to care.

Be more expectant of good care. Participate and be far, far and more selective in where you put your family members than I think many people are. Some people are in situations like I am. They are

in small areas where you don't have choice, but where you do, use it. Check everything out. Go at odd hours, and then just hope, because it is in the hands of other people and the State and the committee and a lot of other people, and after that, that is about all you can do, but hope.

Mr. KORBER. I think some of it has already been said. You have to educate people when they have a family member in a nursing home as to what they can do for that person, things that they should check, try to provide people access to information; but I guess the thing I look at and would say to people is don't be afraid to ask questions and don't be afraid that if you complain that your family member is suddenly not going to get treated properly.

I can tell you some of the families that I am associated with at the nursing home my mother is in, that is their single biggest fear: if I raise a question, if I ask too many questions, if I complain, what is going to happen to mom or dad or my aunt, and that is something that I have talked to people about. And I have shared with them, hey, I have written letters. I have made phone calls, and a lot of them are just terribly, terribly afraid of what is going to happen.

So I think it is information. It is communication, and it is trying to take the fear out of what will happen if you do.

Ms. HOLDER. I would just try to find a facility—if you are lucky enough to have some choice—that has an obviously aggressive vocal family council that clearly is listened to and can bring up problems, and there is evidence that the family council has had success. So it is not just ask if they have one. You have to have some real information and maybe even a visit with that family council to see if they are just paper tigers for the facility.

But I think that is certainly something that we are hoping will occur, that more aggressive family councils start to operate in nursing homes.

Dr. SCANLON. I want to thank you all, very much. Senator Grassley, unfortunately, is not going to be able to return. Life in the Senate, produces so many conflicts in schedules, and this is very understandable. He sends his regrets, though it certainly indicates nothing about his commitment to this issue.

I think we all recognize the committee's role in shedding light on this important question and in continuing to keep our focus on that. I know that out of today's session, that for GAO, I think we have emerged with a number of studies that we have to think about doing, and it is certainly consistent with the fact that we believe that we are going to continue working on this issue on a continuous basis, knowing that that is important to contribute to correcting the situation that exists today.

So I want to thank all the panelists again and all the members of the audience for their very sort of insightful questions and all the insightful comments that have come from the panel. Thank you again.

[Whereupon, at 12:02 p.m., the forum was adjourned.]

APPENDIX

National Committee to
Preserve Social Security
and Medicare

Statement of

Martha M. Mohler RN, MN, MHSA
Senior Policy Analyst
National Committee to
Preserve Social Security
and Medicare

Before

The Senate Special Committee on Aging

Forum on Nursing Home Consumer Concerns

September 23, 1999

10 G Street, NE, Suite 600 • Washington, DC 20002-4215 • 202 216-0420 • www.ncpssm.org

Chairman Grassley, Senator Breaux and members of the Committee, good morning. I am Martha Mohler, a Senior Policy Analyst at The National Committee to Preserve Social Security and Medicare. The National Committee, is a nationwide grassroots senior advocacy and educational organization with some five million members and supporters. We appreciate this opportunity to testify about nursing home consumer concerns.

National Committee members have spouses, relatives, neighbors, and other friends in nursing homes. We recognize that any family may, at some time, need to seek nursing home care for a loved one. Years of providing home care for a very dependent person bring many families to a point where they lack energy and resources to continue (especially when round-the clock care is needed). Many dependent people have no willing family to provide or oversee home care.

Safe nursing homes are very much needed. It is essential that these facilities provide excellent preventive, supportive care.

HCFA solicited consumer concerns as part of the President's Initiative to improve nursing home care. But, curiously, the HCFA reports to Senator Grassley do not emphasize that staffing was a frequently cited consumer concern. Staffing was identified as a priority concern by consumer

consumer representatives meeting with Administrator DeParle, in HCFA conference calls with consumer group representatives, in HCFA meetings to discuss abuse prevention, in HCFA meetings soliciting consumer comments on new survey protocols, and in meetings where HCFA asked for advice about information consumers want or need to help them select a nursing home.

Consumers expect and need professional nursing care in nursing homes, and they quickly see the risks inherent in understaffing. Nursing home populations include people in stages of recovery from acute illness or surgery, people dependent on skilled support. Chronic illness and diminished functional capacities can make both long-term and short-term residents subject to changing health status. Good nursing care is supportive care that emphasizes comfort, restoration and/or maintenance of function and prevention of avoidable injury and complications. Residents may require assistance with any or all the basic activities of daily living. Many residents have chronic illnesses or disorders that require medication and treatments at regular intervals. Cognitive impairment, mental and emotional problems are common among nursing home residents and caregivers need special understanding, patience and communication skills to help them. Delicate balance of physiologic systems can be

upset by a variety of occurrences that alter health status. Changes in a resident's health status must be promptly observed and addressed.

Providing good nursing care consistently for many people in a congregate setting is a constant challenge of teamwork, coordination and professional judgment. Registered Nurses (RNs) are licensed to plan nursing care, supervise, evaluate, administer and participate in direct care. RNs are legally accountable for the quality of care they delegate to Licensed Practical Nurses (LPNs) and Nursing Assistants (NAs). Unfortunately, responsible nursing delegation does not always happen in many nursing homes. Resident care is often relegated to minimally trained staff who are given impossible workloads and little or no professional nursing support, training and supervision. This summer a Georgia ombudsman described conditions that remind us of the kinds of staffing problems we hear about from across the country: *"... In our area in northwest Georgia, we continually verify reports that nursing homes are operating with only one nursing assistant to care for as many as 30 or 40 patients. ... And, at times especially on night shifts, weekends, and holidays, it is commonly verified that nursing homes leave only one nursing assistant to care for as many as 50 or 60 patients, many of whom require total care. This means that during these times, helpless patients are left lying without food or water in their own boldily wastes without any attention. We walk thru the halls during these times*

and hear patients begging for something to eat or drink or to be gotten up out of filthy beds they have been forced to lie in for hours. We hear constant complaints from concerned visitors who witness meals left in rooms of incapacitated residents and then brought out by rushed employees and thrown away untouched. Some of these patients who may see the meal is there but cannot reach it or set it up due to physical infirmities. As a result of this kind of ongoing neglect, critical medical needs are neglected and patients develop painful and debilitating conditions such as bedsores to the muscle or bone and painful contractures of the joints, conditions that can often be avoided with just simple basic nourishment and care."

Throughout the past three decades, while nursing expertise and medical knowledge was expanding in the United States, poor care at "nursing facilities" was still continually reported. Archives of the Senate Special Committee on Aging and reports of the Institute of Medicine document that poorly qualified staff and inadequate numbers of direct care staff were repeatedly cited as a cause of poor care.

When staffing is inadequate, corners are cut and care is missed. In urgent situations professional judgment should determine the ordering of priorities. Residents who frequently lack basic care suffer discomfort and avoidable complications. They lose continence when

they are not regularly assisted with toileting. They get malnourished when they are not given adequate assistance with meals. They get bowel impactions and altered blood chemistries when they do not get adequate assistance with fluid intake. They lose muscle tone and mobility when they are not regularly assisted with exercise. They develop pressure sores when they are not frequently repositioned and given skin care. They become acutely ill when signs of infection, cardiovascular or respiratory problems and drug reactions are not quickly noted and addressed. They become depressed when they have no meaningful activities, when they must endure unrelieved pain or discomfort, or when they become isolated from contact with relatives and friends. Isolation from others is abetted by lack of assistance with personal hygiene and grooming and care of their clothes. Residents are injured in struggling to help themselves when no one responds to their calls for help. They are at risk of mental and physical harm when chemical and physical restraints are used as substitutes for supportive care.

Without competent professional coordination of care, all nursing home residents are at risk of poor care. Without enough people to hear and see what is going on, frail disabled people are vulnerable to exploitation, neglect and outright abuse.

6

WHAT SHOULD BE DONE?

A strong minimum nursing service staff standard is needed for direct care nursing staff that requires reimbursement for and provision of sraff in proportion to the number of residents being served, and professional nurse direction and participation in the delivery of care at every hour of the day and night.

The current federal requirement of "sufficient nursing services" needs to be made more precise. At least forty states have added more specific minimum requirements, at one time or another, but these have often been too minimal to assure the capacity to deliver basic good care.

Surveyors need to focus on the adequacy of staffing to determine that facilities are taking appropriate precautions to assure their capacity to provide good care at all hours. They need reference to reasonable minimum standards for number and distribution of staff around the clock and a methodology for determining additional staff needs. An experience of Nursing Home Monitors Inc. illustrates the need for a strong federal staffing standard. Their complaints of poor care were validated, but the alleged underlying inadequacy of staffing could not be validated by the state because the facility met the very minimal state requirement. [Details are attached.]

We recommend Congress take several actions:

1) Eliminate the provisions that allow waivers to the current federal licensed nurse requirement. In the case of Medicaid certified facilities, these waivers could allow facilities to operate with no licensed nurses.

2) Initiate a minimum-staffing standard advocated by the National Citizens Coalition for Nursing Home Reform and a methodology to determine additional staff needed to meet the care needs of any given nursing home population.

3) Require that protections of federal law extend to all residents of a nursing home that is, in any part, certified for Medicare or Medicaid participation. Hospital certification requirements for Medicare or Medicaid participation apply to care of all patients, regardless of payment source, and history has shown that protections of nursing home certification are needed for all residents. Private pay residents need just as much help and they are very vulnerable to poor care and exploitation.

4) Require that facilities post the resident census and nursing service staffing for each unit each day, so residents and families know who is on duty, who is in charge, and the ratio of staff to residents.

5) Require that facility annual staffing reports be stated in terms of qualifications and number of staff on duty for each hour of the day,

as was required prior to 1992. [The prior form is attached as well as an alternative form suggested by a number of organizations.]

6) Disclose facility staffing to the public to assist consumers in comparing and choosing facilities.

7) The current HCFA OBRA '90 mandated staffing study needs to be redesigned. The current effort does not appear to be a practical approach to determining either the need for or the design of a safe staffing standard. Expert nurse administrators who are recognized for delivering excellent care should directly guide the design of the study; and existing validated nurse staffing methodologies should be evaluated.

ACCOUNTABILITY THROUGH STANDARDS

Direct care must get first priority in the use of nursing home revenues. Minimum staffing requirements are a way to explicitly dedicate funding to direct care, as the price of doing business with Medicare and Medicaid. The minimum must be substantial enough to enable delivery of basic care for each resident at all hours of the day and night, if a provider should decide to staff only to the minimum.

The staffing requirement should be simple enough for families, residents, ombudsmen and staff to observe its implementation. This

monitoring is needed, because annual inspections, alone, afford too little protection.

Although provider institutions and state budget officers voice thoughtful concerns about cost and availability of personnel, we respectfully note that these are problems to be solved, not treated as insurmountable barriers to providing good care. Set an appropriate policy for enabling good care and then find the resources to implement it. Current uses of nursing home funds by providers should be carefully evaluated before estimating the need for additional public funding.

The Georgia ombudsman noted, *"...in our area almost 90% of nursing home services are paid for by federal and state Medicaid funds. This year Medicaid in Georgia increased the nursing home budget by over 70 million dollars. Yet efforts to have even a portion of these funds earmarked for direct care failed. Therefore, we do not expect to see any of these funds trickle down directly to the patients. ... Please help us address this critical issue."*

PRESS CONFERENCE OF JULY 20, 1999 CONCERNING LEGISLATION TO REAUTHORIZE THE OLDER AMERICANS ACT

STATEMENT OF CINDY WADE

My name is Cindy Wade and I am one of 17 regional coordinators of Long-Term Care Ombudsman services for a 15 county area in northwest Georgia. Our program serves the residents of 39 nursing homes and 89 personal care homes in northwest Georgia. In the facilities in our service area there are a total of approximately 5400 residents. Many of these residents are totally incapacitated either physically, or mentally, or both and many have no family or friends to look out for them. Consequently, these individuals are isolated and totally vulnerable and are at great risk of abuse, neglect, and exploitation.

Our program receives an extremely high number of complaints against facilities as well as a high number of requests for other types of services. Last year our program served 1908 individuals, 757 of these complaints were opened as ongoing cases, with the remaining 1151 being served by information and referral services. Our caseloads are very high and we need more staff, and more volunteers, to enable us adequately and timely to respond to the high number of individuals requesting our services. We also need more staff to do regular outreach and monitoring of those patients who are too incapacitated and without anyone to contact us in their behalf. There are still many residents and their families who have never heard of the Ombudsman Program. More ongoing outreach and individual advocacy is desperately needed on behalf of these most infirm residents.

Ombudsman and other Title VII protection and advocacy programs also need to be strengthened for the frail and incapacitated elderly and disabled who receive long-term care services in their own homes. Georgia's Medicaid Program should be commended for increasing long-term care options to enable many to avoid being placed unnecessarily in a nursing home and instead allow them to receive needed services at home. Greater advocacy is needed to ensure that state and federal funds pouring into these contracted services are used for the services intended. Also, advocacy programs help ensure that all available options and services are explained to the patients so that they are fully informed about the programs and services available to them.

Finally, I would like to bring to your attention a crisis currently happening in most of the nursing homes in my state of Georgia, as well as from what I am told, also all around the country. This crisis is that nursing homes are operating without sufficient staff to care for the patients and because of this lack of care givers nursing home patients are being severely neglected.

In our area in northwest Georgia, we continually verify reports that nursing homes are operating with only one nursing assistant to care for as many as 30 or 40 patients. And, at times especially on night shifts, weekends, and holidays, it is commonly verified that nursing homes leave only one nursing assistant to care for as many as 50 or 60 patients, many of whom require total care. This means that during these times, helpless patients are left lying without food or water in their own bodily wastes without any attention. We walk thru the halls during these times and hear patients begging for something to eat or

drink or to be gotten up out of filthy beds they have been forced to lie in for hours. We hear constant complaints from concerned visitors who witness meals left in the rooms of incapacitated residents and then brought out by rushed employees and thrown away untouched. Some of these are patients who may not, due to mental incapacity even know the meals are there. Others, may see the meal is there but cannot reach it or set it up due to physical infirmities. As a result of this kind of ongoing neglect, critical medical needs are neglected and patients develop painful and debilitating conditions such as bedsores to the muscle or bone and painful contractures of the joints, conditions that can often be avoided with just simple basic nourishment and care.

In Georgia, the Ombudsman Program has tried everything to draw attention to this issue. We have gone to legislators, state agency officials, and industry representatives without any success. We have had large public hearings and sent petitions of thousands in our state outraged about this problem. Yet nothing has been done and if anything the problem is now worse. Industry officials openly admit they are short staffed and continue to operate that way. This is a nearly 50 billion dollar industry in our country and in our area almost 90% of nursing home services are paid for by federal and state Medicaid funds. This year Medicaid in Georgia increased the nursing home budget by over 70 million dollars. Yet efforts to have even a portion of these funds earmarked for direct patient care failed. Therefore, we do not expect to see any of these funds trickle down directly to the patients.

I believe the public has a right to demand that the basic needs of patients

are not neglected. We want more than just basic care for these patients. We want enough qualified staff to ensure patients receive a high quality of care. But, as we strive for this level of quality nursing home care, Congress and the public should demand that the nursing home industry is no longer allowed to continue these practices that are resulting in the ongoing neglect of the patients' most basic needs. Please help us address this critical issue. Thank you for allowing me to speak to you today.

Nursing Home Monitors

6111 Vollmer Lane, Godfrey, Illinois 62035 • Phone/Fax: (618) 466-3410

...dedicated to protecting nursing home residents.

Re: Staffing

"Even when it was determined that 100% of the sample was not getting its basic needs met, there was no citation for Lack of Staff because the facility met the Illinois minimum staffing standard.

Inspectors are discouraged from citing for Lack of Staff using the federal guidelines when needs go unmet because the citations do not stand up in court. At appeal hearings the industry's argument is that: "All the staff in the world is not sufficient if they are not doing their job" And the game goes on.

There is a desperate need for an adequate federal minimum staffing standard that is verifiable and enforceable".

Violette King, president Nursing Home Monitors

(Complaint #9741260 Docket No. NH 97-G267 St. Paul's Home, Belleville Illinois)

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July 20, 1999

A LJ'S FINAL ORDER AND DISCUSSION OF COMPLAINANT'S APPEAL OF INVALID UNDERSTAFFING DETERMINATION

Docket No. NH 97-G267

GOALS:

- To compel the state to issue more staffing citations based on the ***federal standard*** in order to eliminate the nursing homes' constant defense that the State finds their staffing adequate.
- To show how difficult it is to get understaffing citations using the federal standard even if 100% of the sample is not getting its needs met.
- To stress the need for a federal minimum staffing standard.

In Illinois we have the right to appeal the State's ***invalid*** determinations of allegations filed in complaints against nursing homes.

We use the appeal system in order to get the State to conduct better investigations. Inspectors know that they may have to defend their methods and findings under oath at a hearing brought about by the complainant.

The system is not perfect. The Administrative Law Judges are State employees and the final determinations are made by the Director of the IL Dept. of Public Health! Even though we lose many more cases than we win, it has proven to be a very useful tool for advocacy.

In this complaint investigation all our allegations were found to be valid except the allegation of understaffing which was determined to be ***invalid***. Because **6 of 6 residents in the sample did not have their needs met** and the State failed to prove that they had interviewed family and residents regarding the adequacy of staffing, we filed an appeal.

This facility was woefully understaffed but still met Illinois' weak minimum staffing requirements. If a stronger minimum staffing standard were in place they would easily have been cited for understaffing. ***As it is, the inspectors are advised not to cite on the federal standard because it cannot be defended at the facilities' appeal hearings.***

The judge who heard this case is the brightest of all the ALJ's we have dealt with but even with compelling evidence she was not able to reverse the invalid staffing determination. The argument by the State's attorney that "all the staff in the world is not sufficient if they are not doing their job" was more compelling.

"Copies of the Final Order available from Violette King," 618-466-4310

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

IN RE COMPLAINT NO. 9741260 (St. Paul's Home)	)	Docket No. NH 97-G267

FINAL ORDER

The Administrative Law Judge has filed with the Illinois Department of Public Health the report of all of her acts and doings together with her recommendations in this matter. The Director of the Illinois Department of Public Health has delegated to the undersigned the authority to review the record herein and issue a final order. The undersigned, after careful review and consideration of the entire record, adopts the entire record of these proceedings, including the findings of fact, conclusions of law, and recommendations of the Administrative Law Judge's report attached to this Order.

Based on the record of the above-referenced proceedings and of the adopted findings and report of the Administrative Law Judge herein, the following is hereby ordered:

1. The findings and determinations of Complaint No. 9741260 are affirmed.

2. This order is a final administrative decision within the provisions of the Nursing Home Care Act and the Administrative Review Law. Any petition for judicial review of this decision shall be filed not later than fifteen days after receipt of this decision.

William A. Bell, Deputy Director
Office of Health Care Regulation
Illinois Department of Public Health

Dated this 17th day of June, 1999.

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

IN RE COMPLAINT NO. 9741260 (St. Paul's Home)	)	Docket No. NH 97-G267 ALJ Roma Barksdale Larson presiding

ADMINISTRATIVE LAW JUDGE'S REPORT AND RECOMMENDATION

On April 22, 1997, Violette King wrote a letter to William Bell, Deputy Director of the Illinois Department of Public Health concerning St. Paul's Home of Belleville, Illinois and requesting an investigation. The Department investigated Mrs. King's complaint and issued violations to the nursing home as a result of its investigation of the complaint. In a letter dated October 7, 1997, Mrs. King requested a hearing to contest the portions of her complaint that were classified as invalid by the Department.

A prehearing conference was held on November 3, 1997. During that conference, Scott Albertsen, the Department's staff counsel, agreed to provide some further information requested by Mrs. King in addition to the standard discovery he had previously produced. At a telephone status conference held November 17, 1997, Mrs. King indicated that her concerns had not been fully addressed and the parties agreed on a hearing date.

A hearing was held February 6, 1998 in the offices of the Illinois Department of Public Health in Springfield, Illinois. Scott Albertsen appeared on behalf of the Department. The Complainant Violette King represented herself.

Mrs. King's basic contention was that the Department had done an inadequate job of evaluating the evidence it gathered in its investigation of the complaint. Although the Department found most of her allegations as characterized by the complaint intake division "valid" and had issued violations as a result of the investigation, the Department had determined the "lack of staff" allegation to be "invalid."

The Department determined that the facility met the minimum staffing requirements set out in the state regulations. Mrs. King's position was that the Department should also consider whether the federal requirement regarding staffing had been met. The federal regulation at issue is 42 CFR 483.30(a)(1)(2), which requires that a facility have "sufficient staff to provide services to attain or maintain the highest practicable physical, mental, and psycho-social well-being of each resident as determined by resident assessments and individual plans of care."

Mrs. King relied on certain findings in the Department's investigative file to support her contentions, including the time passage before one resident's broken arm was fitted for a cast and the fact that six of six sampled residents were found in need of personal care.

For the Department's case in chief, Mr. Albertsen proffered portions of the file prepared by the surveyors who had performed the investigation. Department Exhibit 3 consists of 30 pages showing the materials gathered and calculations performed as part of the staffing review conducted during and after the survey. Department Exhibit 2 was proffered to refute Mrs. King's contention (*Tr. p. 13*) that residents had not been interviewed.

Findings of Fact

Based on all of the evidence, including the testimony of witnesses and admitted exhibits, and having considered the credibility of the witnesses and arguments of counsel and the complainant, I find the following facts proven by a preponderance of the evidence:

1. The Department investigated Complaint No. 9741260 and issued both state and federal violations as a result.

2. Although the evidence suggested areas of possible improvement in surveys in general, it did not show the investigation of this complaint to be inadequate or the determinations reached as a result improper.

Discussion

The issue in this case is whether the the Illinois Department of Public Health properly investigated and determined the allegations of Complaint No. 9741260.

The Nursing Home Care Act states that "a complainant who is dissatisfied with the determination or investigation by the Department may request a hearing. . .". 210 ILCS 45/3-702. 77 Ill. Admin. Code 100.6(d) spells out exactly what may be contested at such a hearing: ". . .the adequacy of the Department's investigation and its determination as to whether the complaint was valid, invalid, or undetermined and also the Department's determination as to whether to issue any violation as a result of said determination." The burden of proof is on the complainant and the standard of proof is preponderance of the evidence. 77 Ill. Admin. Code 100.6(g).

Mrs. King offered a compelling argument that mere numbers are not always sufficient to determine if a facility is adequately staffed. The counter argument offered by Mr. Albertsen that all the staff in the world is not sufficient if they are not doing their job is also strong. The violations that the Department issued to the facility as a result of this investigation were focused on the quality of the services being provided (or not provided) to the residents. Achieving and maintaining a high quality standard of care is both the mandate of the Department and the mission of advocates such as Mrs. King. It is inevitable that there will be disagreements as to how best to reach such a goal.

From the evidence before me, I cannot say that the Department did not properly investigate and determine the overall situation it found at this facility. With respect to whether residents were interviewed, the preponderance of the evidence does not support the Department's position. A mere check in a box on a form does not prove that interviews were done. The evidence did not prove that they were not done; it was merely inconclusive. Mrs. King's argument that interviews of both residents and family members are critical to a full picture of conditions in a facility is again compelling, and the Department recognizes that importance in its guidelines for investigations. Such interviews should be conducted.

While the evidence presented was not sufficient to prove an inadequate investigation or improper determination in this particular instance, it is noted that the general concerns and specific issues raised by Mrs. King in this case provide instructive insights and reinforcement of what the goals of investigations are.

Conclusions of Law

Based on the Findings of Fact and the Discussion, I conclude, as a matter of law, that the Department's investigation and determination of Complaint No. 9741260 was proper.

Recommended Decision

I recommend that the Director affirm the Department's determination of Complaint No. 9741260.

Dated this 15th day of June, 1999.

Roma Barksdale Larson
Chief Administrative Law Judge
Illinois Department of Public Health

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

IN RE COMPLAINT NO. 9741260, (St. Paul's Home)	)	Docket No. NH 97-G267

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Final Order was sent by certified mail in a sealed envelope, postage prepaid to:

Ms. Violette King
6111 Vollmer Lane
Godfrey, IL 62035

That said document was deposited in the United States Post Office at Springfield, Illinois, on the 21st day of June, 1999.

Roma Barksdale Larson
Roma Barksdale Larson
Chief Administrative Law Judge

cc: Scott Albertsen
Betty Driscoll
Quality Assurance

Proposed Form 1995 (rev. May 1996)

Matrix of Direct Care Nursing Hours

Facility Name:_____ Date:_____ Dates Reported in this Staff Hours Chart:_____to_____

Total Census for This Week:_____ Number of Nursing Units:_____

	MONDAY					TUESDAY					WEDNESDAY					THURSDAY					FRIDAY					SATURDAY					SUNDAY				
	RN	LPN	CNA	CMA	OTH	RN	LPN	CNA	CMA	OTH	RN	LPN	CNA	CMA	OTH	RN	LPN	CNA	CMA	OTH	RN	LPN	CNA	CMA	OTH	RN	LPN	CNA	CMA	OTH	RN	LPN	CNA	CMA	OTH
7AM 3PM																																		
3PM 11P																																		
11P 7AM																																		

110

Instructions:

This matrix is to be filled out by the Director of Nursing to report direct care nursing staff hours for the work week which concluded prior to the start of the survey. Example: if the survey begins on Tuesday, March 27, then the Director of Nursing reports the direct care nursing staff hours for the week starting on Sunday, March 19, and ending on Saturday, March 25. An alternative week can be reported at the surveyor's discretion.

Direct care is defined as not only "hands-on" care but also the planning, supervision and direction of that care, as well as documentation thereof. For each day, enter the number of direct care nursing staff hours worked in each of the eight hour periods listed. If facility shifts do not correspond to the time periods listed on the matrix, divide the hours between time periods to show time worked in each period. Include only those nursing staff hours in which nursing staff are providing direct care to residents. Director of Nursing, Assistant Director of Nursing, etc. time may be reported only to the extent that these persons are providing direct care to facility residents.

Key to Abbreviations:

RN - Registered Nurses, not including the Director of Nursing in facilities of 60 or more beds and RNs with administrative duties only.
LPN - Licensed Practical Nurse and Licensed Vocational Nurse: not including time devoted to duties other than direct resident care.
CNA - Certified Nurse Aide; hours of certified individuals only. (see HCFA 671 for a complete definition of this position)
CMA - Medication Aide; include hours of certified medication aide. (this position is not recognized in every state)
OTH - Other Direct Care Nursing Staff, including nurse aides in training. Do not include volunteer hours.

ISBN 0-16-060444-3