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To the

U.S. Senate Special Committee on Aging

On Improving Nursing Home Transparency, Enforcement and

Quality of Services

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Senator Kohl, Senator Smith and members of the Committee, thank you for the opportunity to speak with you today about nursing home transparency, enforcement and quality. Chairman Kohl, I especially want to express the appreciation of the National Association of State Ombudsman Programs for your years of work on nursing home issues and your support of the Ombudsman Program and State Survey and Certification efforts.

The landmark OBRA 1987 legislation and subsequent regulations and policies aimed at improving the quality of care and life of nursing home residents is to be celebrated. But as 20 years have passed and we still see too many instances of poor quality care and continuing poor performance by certain providers, your efforts to make improvements in this realm are much needed. Nursing homes are an awkward mix of private businesses and public funding attempting to provide care and a home-like environment for some of our most vulnerable citizens. Within this structure and given the level of vulnerability of residents, we must assure that the public has access to meaningful information about ownership, enforcement actions, financial solvency, and staffing in all certified nursing facilities.

Ownership

Congress should require the Centers for Medicare and Medicaid Services (CMS) to collect and publish information on Nursing Home Compare that shows any ownership linkages. The linkages would be determined by common ownership of the real estate, the license, or any management company operating the facility. Additionally, commonality of investors or stockholder with more than a 5% interest, and members of any board of directors or governing body should be available to Ombudsmen and consumers. CMS should also collect and publish information on ownership linkages to other businesses, such as pharmacies, laundry services, food services, etc.

Owners must be accountable to state and federal payment sources, Medicaid and Medicare, and must be required to submit audit results and financial data to demonstrate fiscal solvency of all commonly owned and related ownership entities. Further, accountability to residents should include a requirement for adequate liability insurance, so that residents who suffer wrongful death or other severe harm can pursue their private right of action in a meaningful way.

During 2005, two nursing facilities burned in Michigan. One resulted in 2 resident deaths and partial facility evacuation during the Easter holiday weekend. The other resulted in 2 resident deaths and 60 residents sent to the hospital along with complete evacuation in mid-December. There was no overt connection between these two facilities (such as the same name) and it took considerable effort by the Ombudsman to learn of their common management company. Despite different owners of the real estate, the management and operations of the two facilities were run by the same people. In both cases, inadequate staff training contributed to resident harm. Both facilities had not provided specific training and drills to assure that staff knew how and when to use fire extinguishers and fire doors. The common management company showed a pattern of inadequate training

on fire safety. This is an example of how important ownership linkage information is to consumers and regulators. Had a connection been apparent, regulators could have required a review of emergency procedures in all facilities operated by this management group.

Enforcement

All enforcement actions should be published by facility name on Nursing Home Compare. Actions such as Denial of Payment for New Admissions, Civil Money Penalties, Directed Plans of Corrections, Mandatory Temporary Management, Monitors, Terminations, and Special Focus Facility status should all be clearly listed on the website. Additionally, plain English explanations of these terms must be listed after each usage of the terms so that consumers can understand the sanctions.

Residents of facilities, their loved ones, and the community at large should be notified of enforcement actions taken at facilities. Too often, Ombudsmen hear from residents and families that the termination action is their first notification of the facilities problems. Residents and families at each decertification action where I have been involved say they had no idea the facility was in such trouble. Having this information would support people in making informed decisions during nursing home placement and would give consumers and families information about areas that require vigilance in a facility. If a facility has citations about wound care, and I need that service, I may be more watchful if I have that information. Residents deserve to know.

The complete text of the survey results (the 2567 form) should also be published on Nursing Home Compare. The descriptive text of these reports helps consumers to get a better idea of what violations are cited, and what is needed to correct problems. This narrative helps consumers get a real sense of the problems in a facility, rather than just the technical regulatory description. CMS should be required to post the complete 2567, then to add information about citations overturned or modified on appeal, so that consumers have complete access to facility information.

Another essential tool for residents, families and friends is a standard complaint form. This type of form helps people who have not filed complaints before by prompting them to identify and include all basic information needed to investigate the complaint. Survey and Certification Complaint Units must also continue to provide for telephone complaints, where staff assists consumers in reducing the complaint to writing.

Additionally, local hospitals, hospice agencies, home and community based waiver programs, Area Agencies on Aging, Centers for Independent Living, the Long Term Care Ombudsman, and the Protection and Advocacy Agencies should all be directly notified of state and federal enforcement actions. These entities make referrals to nursing facilities or have clients living in these facilities. They need current and accurate information about facility status to best assist consumers.

Civil Money Penalties (CMP)

Federal CMP funds should be collected without any discount for non-appealed violations. If the violation was severe enough to merit a Civil Money Penalty, there should not be any discount. If the CMP is not correct, or is too harsh and the facility appeals the decision, the appeal process will deal with any reductions or deletions that are merited.

Federal CMP funds should be returned to the State Survey and Certification Agency where the violation took place to be used for:

- Increased staffing for survey teams and Ombudsmen;
- Funding to carry out financial viability audits and reports;
- Financial restitution to any individual resident who was harmed;
- Other quality improvement projects selected by states that provide clear and immediate benefit to residents.

Staffing

The amount and type of nursing staff (R.N.s, L.P.N.s, and C.N.A.s) serving residents in each nursing facility should be posted on Nursing Home Compare. The information should be collected by states from payroll data on a quarterly basis and audited for accuracy, then submitted to CMS. CMS should include an analysis of staffing trends by facility, and whether the facility has increased or decreased its direct care staffing levels by category over the last three years. Additionally, any substantiated complaints about staffing levels should also be listed on Nursing Home Compare.

Staffing shortages continue to plague residents and staff at many nursing facilities. A recent revisit survey at a Michigan facility resulted in a citation for Pressure Sores (F 314 based on CFR 483.25(c)). In the narrative for this citation, an interview with a CNA, who had not turned a resident as stated in his care plan, said the following, "I have 14 residents to care for and 11 residents are total care. It's very hard to turn people every two hours because sometimes we just can't. He (Resident 56) is a two person transfer so we can't answer lights because he could fall. Nurses will turn off the light and then tell us what the resident needs which doesn't help us." Resident 56 was admitted to this facility in December 2006 with no pressure ulcers. By February 2007 he had a pressure sore on this left heel, and by September 2007 had a maggot infestation and infection that required surgery on his Stage IV pressure sore and removal of part of his heel.[1] Clearly this type of severe short staffing is unacceptable and Congress should enact safe and clearly enforceable staffing requirements to assure that no other residents suffer this fate.

Ombudsman Access to Information

All information about Ownership, Enforcement Actions, Civil Money Penalties, Staffing, and Special Focus Facilities must be shared immediately by all State Survey and Certification agencies with each State Long Term Care Ombudsman. Ombudsmen are a

[1] Metron of Bloomingdale, Revisit Number Three to the Annual Survey, 11/20/2007, pp.15, 16.

direct source of information for consumers, and serve as a source of counseling and information for consumers and their families and friends as they consider long term care options. Ombudsman are able to track this information, provide a sounding board for consumer questions, and help consumers understand the complex and multifaceted information they are bombarded with during what is usually a health crisis. I am deeply troubled that not all state Ombudsman have access to this information, and I urge Congress to require states and CMS to share all facility information with Ombudsmen. When Ombudsmen know about sanctions and facility status they can increase visits to safeguard resident safety and well-being. Ombudsmen also need information at the earliest possible time to be prepared to help consumers through the trauma of closure, should the facility become terminated from Medicare and Medicaid.

Ombudsmen should also be consulted in the development of the lists of potential and actual Special Focus Facilities. The data from the Ombudsman program about complaints and issues at facilities would add a consumer perspective to the decision making process around Special Focus Facilities. I urge CMS and State Survey and Certification agencies to establish and use input mechanisms to gather information from the Ombudsmen in each state.

Effect of Enforcement on Residents

For many years, the Michigan Long Term Care Ombudsman Program, and Ombudsmen in many other states, have expressed a need for CMS to hold poor performing facilities accountable, to consistently use strong enforcement action when violations exist, and to enforce all of the requirements for Quality of Care and Quality of Life found in the federal Nursing Home Reform Law of 1987. At the same time, Ombudsmen have expressed great concern over the harm suffered by residents when these same enforcement actions bring about the decertification and closure of facilities.

The Special Focus Facilities program has brought these competing concerns into sharp relief as chronically poor performing facilities receive additional scrutiny and a shortened enforcement cycle while on the Special Focus Facilities list. In Michigan, for the most part, Special Focus Facilities either improve or close. Approximately 5 facilities, slightly more than 1% of Michigan's nursing home supply, close each year in Michigan. During FY 2007, approximately 445 nursing facility residents were forced to move from their homes because of nursing home closures. The majority of these facilities were either in Special Focus status or were on the list of possible Special Focus Facilities.

Almost all of the nursing home closures in Michigan over the last 4 years have been at facilities with a high number of violations, financial problems, a higher than average percentage of their population reliant on Medicaid, and a higher than average percentage of their population made up of younger residents with largely unaddressed mental health needs. Whether the closure is labeled "Regulatory" or "Voluntary" seems largely to depend on the timing of the owner's taking action to surrender their certification, rather than on any substantive difference.

In two recent decertification actions in Michigan, the facilities have sought and received permission from CMS to voluntarily surrender their Medicare and Medicaid certification one day prior to their termination dates. The result in one case was a "Voluntary" closure. During this type of closure, the state has less control and authority over what happens to residents, the facility and corporate staff remains in charge of the building and the relocation of residents. State placement agents, ombudsmen, and community mental health agency staff are far less effective in ensuring residents' rights and choice when the facility or corporation is left in charge. These closure situations in Michigan have resulted in less resident choice about their next placement, much pressure on facility staff, residents and their families to move out quickly, and less effective state oversight during the closure. Congress should add closure provisions to federal law, so that:

- State Survey and Certification Agencies always take control of the relocation of residents during the closure;
- Special fines against owners are levied when residents are not provided meaningful choice in their next living arrangement;
- Specific timelines for each closure are established by CMS and the State Survey agency – these timelines may vary depending on the number of residents, the availability of other acceptable options and the level of risk of harm to residents remaining in the facility during the closure period;
- Federal Medicare and Medicaid payments should not be limited to thirty days after the termination date. Thirty days is often not adequate time to choose a better facility, or to transition to home and community based services. This timeline pushes residents to move to far away facilities, or to other substandard facilities in many cases.

In closing, I applaud this committee's efforts to shed light on nursing home ownership, enforcement, staffing and special focus status. Everyday I hear from consumers who are thirsty for reliable and understandable information about nursing homes. The National Association of State Ombudsman Programs stands ready to provide additional information on residents' experiences and on how information can be made accessible, transparent and meaningful to consumers. We are very grateful for your determined efforts to empower, inform and protect long term care residents.