

SUCCESSFUL TRANSITIONS: REDUCING THE NEGATIVE IMPACT OF NURSING HOME CLOSURES

EXECUTIVE SUMMARY

BACKGROUND AND SIGNIFICANCE

Change is difficult, particularly when one is forced to move to a new location. This is particularly true for vulnerable nursing home residents, most of whom already reluctantly left their homes to move into a long-term care facility and are now dependent on others for all aspects of their lives. For the 1.5 million people residing in the nation's 15,000 nursing homes, being forced to relocate is exceptionally challenging.

Nursing home closures are becoming more frequent, some voluntarily (i.e., owners or boards decide to close for many reasons) and some involuntarily (i.e., state or federal governments force them to close for care or safety issues). Both consumer preference for care in a community setting and state and federal government policy have driven these closings.

Nursing home closings can have serious negative effects on residents. Many residents experience transfer trauma (also referred to as relocation stress syndrome).¹ The response to the stress caused by a transfer or relocation may include depression, manifesting as agitation; increase in withdrawn behavior; self-care deficits; falls; and weight loss.² Closures, and these responses to the stress of moving are occurring nationwide, and may be due to the fact that the closure of nursing homes seems to be inadequately addressed in state and federal laws and regulations and/or poor oversight and monitoring by states and the federal government. When closures are inevitable, better policies and practices can be implemented to minimize the negative impact, including transfer trauma, on residents. Failure to protect dependent nursing home residents in these crisis situations undermines the entire framework of nursing home resident protections established in federal law.

THE STUDY

Given the harm that nursing home closures can cause residents, this study's goal was to make recommendations to lessen or eliminate the possible negative effects on residents of closure.

¹ Manion, P.S. & Rantz, M.J., *Relocation Stress Syndrome: A Comprehensive Plan for Long-Term Care Admissions*, 16 Geriatric Nursing, May/June 1995.

² Murtiashaw, S. *The Role of Long-Term Care Ombudsmen in Nursing Home Closures and Natural Disasters*, National Long Term Care Ombudsman Resource Center, National Citizens' Coalition for Nursing Home Reform (Now The Consumer Voice), January 2000. *Supported by U.S. Administration on Aging.*

Project Objectives

1. Identify current obstacles to the implementation of well-planned, resident-centered discharge planning when a nursing facility closes, either voluntarily or involuntarily.
2. Identify policies, procedures and specific action to overcome these obstacles.
3. Identify “best practices” to achieve the implementation of well-planned, resident-centered nursing home closures.
4. Translate findings into recommendations for state and national policy makers and long-term care ombudsmen to achieve well-planned, resident-centered discharge when a facility voluntarily or involuntarily closes.

Methods

Gathered Information from Stakeholders

Through the use of on-line surveys, in-depth telephone interviews and archival resources, this study gathered information from those people either directly involved with nursing home closures or who are working with individuals who have been involved: representatives of provider associations, union representatives, representatives of ombudsman associations, state survey directors, a representative of the Centers for Medicare and Medicaid Services (CMS), state and local ombudsmen, organizational and independent advocates, and families and residents themselves. The surveys asked a series of questions related to what makes for a successful transition for residents, what obstacles are limiting this success, what the possible solutions are to overcome these obstacles, the stakeholders’ understanding of the role of the state and whether they believed state and federal requirements for closure are protective enough. This information was then aggregated, categorized and used to develop recommendations for conducting a successful transition for residents. One-on-one interviews posed similar questions, asking for more detail and explanation of ideas.

Developed Case Studies of States with “Best Practices” and a Case Study in one State Demonstrating “Poor Practice”

Three states were selected for individual case studies based upon “best practices” related to nursing home closures. Information from representatives of groups (stakeholders) involved in nursing home closures in these three states was obtained by phone interview. These groups included state and local ombudsmen, state regulatory agencies, disability rights groups, rate setting agencies, providers, and mental health agencies. Each individual was asked a standardized set of questions to determine: their role in their state’s nursing home closure protocols; details about the closure process; how the process began; what they think is unique about their process; what they think are the strengths and weaknesses of their process; how they overcame any problems that arose; if there are any plans for changes; and if any financial resources are used. The case studies described each state’s current closure process and highlighted its best practices and future work.

The case study of an actual closure that led to a negative outcome for residents and families was developed after gathering relevant documents and conducting interviews with: the local ombudsman involved, a family member, an advocacy organization deeply involved in the closure and the follow up, and the state regulatory agency.

A summary of innovative practices from seven other states is also provided.

Findings from Surveys and Interviews

One of the clear messages from the study is that state and federal oversight and enforcement must be stronger to both improve care before a facility is forced to close and to hold providers accountable for following the rules when a facility does close. The suggestion that we need better enforcement was raised repeatedly by those interviewed. Many of the ombudsmen, advocates, family members and residents thought that involuntary closures due to substandard care or immediate jeopardy would not happen if poor care practices were appropriately cited and remedies imposed in a timely manner. Some thought that the threat of closure by the State Survey Agency or CMS is used, and then rescinded, so often that providers don't believe they will ever be decertified or lose their licenses, and thus they continue to tell residents not to worry even when threatened with decertification. Then if the facility is actually forced to close for failure to establish compliance with standards, the residents and families are blindsided. Respondents felt that if enforcement action was taken earlier and more consistent, i.e. deficiencies accurately cited and categorized by scope and severity, the full range of available remedies imposed; and providers were held accountable with meaningful plans of correction developed and implemented to address deficiencies, care might improve before the facility is forced to close.

Local Ombudsmen: "...resident belongings being trashed-bagged up with no labels as to whom it belongs to." "Possessions, chart and meds not going with resident." "Residents sent without proper discharge paperwork." "Moving day chaos." "Families not knowing where residents are moved." "The closure was one of the worst experiences of my life!"

Findings from the First On-Line Survey and Interviews

Responses from the first on-line survey, sent to State and Local Ombudsmen, residents, advocates, and family members, revealed the following:

- Nursing home closures are problematic for residents.

- Generally voluntary closures go more smoothly, although some ombudsmen, advocates, families, and residents found problems with voluntary closures.
- Success in voluntary closures must include ombudsman involvement, accurate information, and good discharge planning.
- Success for involuntary closures involves participation of the ombudsman and proper monitoring by the State.
- There are 6 (six) major obstacles to a successful transition for residents, both voluntary and involuntary closures:
 1. Lack of appropriate and nearby placements either because there are no vacancies or providers do not want to take a specific resident.
 2. Poor discharge planning by not providing important information about alternative placements or not explaining choice and rights to residents and families.
 3. Lack of communication, including accurate communication, by providers.
 4. Poor notice/not enough time to find new placements.
 5. Staffing issues such as staff leaving, staff stress and bitterness.
 6. Transfer trauma.
- There must be better requirements for closure, more provider accountability and better state or independent monitoring are needed.
- The State should be more proactive and take the initiative in helping residents transition to both an appropriate and desired new home for care and services.

Ideas for Overcoming the Obstacles

A second anonymous on-line survey was sent to all ombudsmen, advocates, families and residents who received the first survey. Respondents were asked to share any ideas they had to solve the problems or overcome the obstacles or barriers to a successful transition for residents raised by the majority of respondents in the first survey. Below is a table listing the obstacles and possible solutions they raised:

OBSTACLE	SUGGESTIONS TO OVERCOME
Lack of appropriate and nearby placements either because there are no vacancies or providers do not want to take a specific resident.	<ul style="list-style-type: none"> • Give the receiving facility monetary incentives to take a resident. • More fines, regulations and oversight. • Encourage the receiving facility to take residents who are difficult to place.
Lack of communication, including accurate information, with residents and families.	<ul style="list-style-type: none"> • Obtain participation of the Ombudsman early. • Require new protocols and rules.
Poor discharge planning by not providing important information about alternative placements or not explaining choice and rights to residents and families.	<ul style="list-style-type: none"> • Require an outside entity to conduct the discharge planning. • Ensure that ombudsmen participate in informing residents/families about rights, options. • Require that the State Ombudsman see and comment on closure plan before state approval. • Give the ombudsmen a list of all residents being moved, including what new location and when movement occurred. • Promulgate new rules related to how discharges are handled on day of transition.
Staffing issues such as staff leaving, staff stress and bitterness.	<ul style="list-style-type: none"> • Provide/require more training and education on closure issues. • Be sensitive to staff who may be frightened or bitter due to the closure. • Provide assistance and referrals for new job opportunities once the facility has closed. • Promulgate new rules related to staffing numbers, closure plans, staff payment accounts, state supplement of staff if needed, bonuses and severance pay. • Ensure effective enforcement, including fines, if resident care and quality of life is compromised due to inadequate staffing levels.
Transfer trauma experienced by residents.	<p>BEFORE MOVE</p> <ul style="list-style-type: none"> • Give residents control over where they move. • Prepare residents for relocation. <p>AFTER MOVE</p> <ul style="list-style-type: none"> • Assist residents in adjusting to new location.
Poor notice/ not enough time.	<ul style="list-style-type: none"> • Require more notice to residents and families of an impending closure. • Put notice rules into statute.

Findings from Case Studies

Best Practice Examples: Three state nursing home closure processes have been selected to highlight: Connecticut, Ohio and Wisconsin. All three have a number of innovative practices, some of which seem to respond to the obstacles to a successful transition for nursing home residents identified by the survey respondents. Wisconsin and Connecticut's case study focuses on their process with voluntary closures and Ohio's on involuntary closures.

All three states developed and continue to improve their systems by bringing together pertinent state agencies to focus on nursing home closures.

Ohio was selected because of its creation of a resident relocation team that meets to continuously communicate and develop solutions to problems in homes that may be threatened with closure; its advance work, long before a nursing home is forced to close, at the time a facility is in danger of being terminated from the Medicare and Medicaid programs; its focus on the least restrictive setting; its help for facility staff; and its significant follow up with all relocated residents.

Connecticut's best practice centers on its use of its certificate of need process. It can deny the ability of an owner to close a facility if it finds it is not in the public's best interest. In addition, the state requires a public hearing before it will make a decision to approve or disapprove a request by a facility to close. Lastly, the State Legislature passed a statute that mandates that the State Ombudsman send a notice to all residents at the same time the provider applies to the state for approval to close to explain rights that residents have. Thus, they will get this notice at the same time they learn the possibility of closing.³

Wisconsin, the third best practice state, has put all its closure rules in statute which gives residents more protections. It has created a "relocation specialist" within the Office of the State Ombudsman who gets involved whenever five or more residents are moved and in all closures in the state; it has developed a relocation team comprised of relevant state, local and advocacy agencies; it has held "lessons learned" meetings to discuss what it has learned from complicated closings; and has put a major focus on transfer trauma and staffing issues, developing a detailed manual for providers addressing these issues.

Poor Practice Example: Also highlighted is a case study of an involuntary closing in New York State that demonstrated practices which resulted in significant negative experiences for residents. Residents and family members were provided inadequate or inconsistent information about the facility's closure and thus had little time to find appropriate alternate placements; local facilities were permitted to refuse to accept certain residents, resulting in a number of residents being sent a significant distance from friends and family; residents were

³ Public Act No. 16-8: An Act Concerning the Long-Term Care Ombudsman's Notice to Nursing Home Residents.

not provided with a choice of facility, but instead were pushed to accept any open bed, or placement in poor performing facilities.

DISCUSSION

The state case studies reinforce the data collected in the on-line surveys and the one-on-one interviews. Many of the obstacles to a successful transition for nursing home residents have the potential to be overcome by the processes in the best practice states.

The state case studies reinforce the data collected in the on-line surveys and the one-on-one interviews, as they show that several of the obstacles to a successful transition for nursing home residents have the potential to be overcome by the implementation of specific processes and requirements at the state level, and from quick and concerted action by the appropriate State Agencies and the Long-Term Care Ombudsman Program. Developing processes for timely communication with residents and families, delineating roles and responsibilities for all state agencies, creation of state-developed closure manuals that outline the processes to be followed by the closing facility, as well as the state agencies and programs overseeing the closure, are all strategies being employed by states to assure that a nursing home closure occurs with the least amount of negative impact on residents as possible.

Through the data collection and analysis, and interviews with state program representatives, we were able to identify a range of recommendations for CMS, for State Agencies, and for State Long-Term Care Ombudsman Programs that would enhance protections for residents facing relocation, and help better prepare them for the moving experience.

RECOMMENDATIONS FOR CMS

On March 19, 2013, CMS finalized its requirements for long-term care facilities closures.⁴ In response to public comments urging more specific requirements, CMS stated, “We appreciate the commenter’s suggestion; however, we do not believe it is necessary to include specific requirements for the plan in the regulation text. We want to allow each LTC facility the flexibility to develop a plan that would most effectively protect the residents’ health, safety, and well-being.”

The experiences of our study respondents and interviewees - residents, family members and ombudsmen - clearly indicate that more specific requirements are indeed necessary.

Although the final rule states that “the administrator (must) include in the written notification of closure assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs,

⁴ <https://www.federalregister.gov/articles/2013/03/19/2013-06276/medicare-and-medicaid-programs-requirements-for-long-term-care-ltc-facilities-notice-of-facility>.

choice, and best interests of each resident;" and, "the plan must include assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident," **we found that in many cases this does not happen. Far too often the closure process forces residents to move to locations they do not choose or want.**

We therefore make the following recommendations that CMS require of the state regulatory agency:

General Recommendations:

1. Require states to develop a coordinated state team focused on closure and relocation.

We recommend requiring states to develop a "relocation team," consisting of all relevant state agencies/programs, including the regulatory agency, the Office of the State Ombudsman and the agency that deals with community care, or manages the Money Follows the Person (MFP) program. This team should create a state closure protocol and manual defining the different roles of each agency, the specific closure process, the responsibilities of the closing facility, the responsibilities of the receiving facility and the rights of residents and family during a closure. The team should meet regularly regardless of whether there is a closure pending. The model described in the Ohio case study should be followed.

2. Require states to include the State Ombudsman in the closure plan review and require the state to consider State Ombudsman comments before its approval of the plan.

Our study indicated that one of the most important elements of a successful transition for nursing home residents is active participation of the long-term care ombudsman.

3. Make available Civil Money Penalty funds to support residents during the closure process.

Federal law permits the use of Civil Money Penalty funds to be used to support and protect residents of a facility that closes or is decertified. These funds should be used to support state efforts to more effectively plan for and coordinate the closure process by, for example, establishing a Relocation Team, or developing a closure manual. Additionally, the funds should be made available if needed during the closure process for assisting residents' transition to other facilities or home and community based settings, or in some instances, to impose a management oversight company or temporary manager to oversee the closure.

4. Provide clarity to state licensing and certification agencies about their role in closures.

Federal law requires the state survey agency to approve a nursing facility's closure plan, but based on responses to the surveys by ombudsmen, advocates, and survey directors on state closure processes, and interviews with directors of state licensing agencies, CMS should provide additional clarity through guidance and training as to the role of the state survey agency during the closure process, which should include not only approval of the closure plan, but also oversight of the plan's implementation, including protection of the rights of the residents forced to move.

Recommendations Addressing Obstacles to a Successful Transition⁵:

- 1.** Require that any facility, chosen by the resident, which has a vacancy but chooses not to admit her/him, must document and send to the state the reasons for this denial.

If the facility claims it is unable to care for the resident, the facility must identify specifically which care needs they are unable to meet and why. The state must evaluate the reasons presented by the facility. If the state agrees that the reasons for the denial are legitimate, it must be proactive and try to find a solution to the problem. Refusing facilities should be urged to interview and assess the resident themselves to accurately determine whether they can meet the resident's needs

We further recommend that if the state determines that the documentation presented seems to be a violation of Civil Rights laws, the state must issue a citation that leads to a significant fine. To come back into compliance, the facility must a) admit the resident who was denied admission (if the resident still wishes to live in the facility); and b) change its admission policy to fully comply with the federal Civil Rights laws.

- 2.** Require states to bring in independent discharge planners, hire a management company, or apply for a receivership, if complaints by residents, families and ombudsmen and on-site monitoring by state agencies indicate a lack of appropriate discharge planning on the part of closing facility staff.
- 3.** Require a state to develop a system for residents and families to file complaints about the closure process and receive an immediate response; review all complaints received during the closure to identify problems; perform root cause analysis; make improvements based on analysis; and submit complaint review/analysis to CMS.

⁵ Many of these recommendations addressing obstacles were suggested by respondents to the questionnaire who were experienced with nursing home closures.

4. Require states to develop a closure manual for providers, which include checklists of tasks they must carry out before any resident is transferred.
5. Require on-site monitoring of the closing facility by the relocation team described above.
6. Require the regulatory agency to hold a facility accountable, through a citation and fine, for knowingly providing inaccurate information regarding closure to residents and families.
7. Make mandatory for providers each of the tasks listed as guidance in the interpretive guidelines. As noted above, our study indicates that many providers are not doing them voluntarily; thus they must be mandated.
8. Require a facility to remain open until all residents are transferred to an appropriate location of their choosing. If the state or CMS is concerned about poor care in the closing facility, or the owner runs out of funds, the state must be prepared to impose a receiver, use the federal temporary management remedy in federal law, or hire a management company to manage facility operations.
9. Require a facility to notify all residents and families of an involuntary impending closure at least 60 days before the closure. Currently, the requirement of 60 days is only for a voluntary closing; the Secretary will determine the appropriate time for an involuntary closing. If the Secretary determines the facility must be decertified in less than 60 days because residents are at risk, CMS must require the state to take over the facility in a receivership, use the federal temporary management remedy in federal law, or require the facility to hire independent overseers to monitor and care for residents until all are transferred to an appropriate location of their choosing. Medicaid/Medicare funding must be continued during the relocation process as required under § 488.450.
10. Require the state relocation team to focus on the needs of staff by notifying the State Departments of Labor to help with unemployment insurance and finding a new position.
11. Require the facility closure plan to include how the facility will make sure that there is enough staff to care for the residents and how it may help staff find new employment.
12. Require the facility to report, on a daily basis, the number of registered nurses, licensed practical or vocational nurses and certified nursing assistants providing direct care and also the resident census for each shift to the state relocation team or regulatory agency to ensure adequate staffing.

13. Require the state to hire additional outside staff if necessary, paid for by the closing facility.
14. Require that the facility closure plan submitted to the state delineate how the closing facility will attempt to lessen any transfer trauma.
15. Require both closing and receiving facility to undertake specific tasks to lessen transfer trauma.

RECOMMENDATIONS FOR STATES⁶

General Recommendations:

1. Create a “relocation team,” consisting of all relevant state agencies/programs, including the regulatory agency and the Office of the State Long-Term Care Ombudsman to a) meet on a regular basis; b) establish a formal state closure process; c) develop a manual that defines roles, responsibilities and timeframes; d) discuss any problems related to closures; and e) be on-site during a closure.
2. Post on the state regulatory agency’s website, the State’s requirements and processes around closure, including requirements of providers, rights of residents, and tasks and responsibilities of the relocation team.
3. Pass legislation to codify the state closure process, including provider requirements, residents’ rights; and relocation team tasks.
4. Develop a system for residents and families to file complaints about the closure process and receive an immediate response; review all complaints received during the closure to identify problems; perform root cause analysis; make improvements based on analysis; and submit complaint review/analysis to CMS.
5. Use Civil Monetary Funds (CMP) to support a successful transition for residents in those instances where the closing facility is unable to fund such activities.
6. Introduce and pass a requirement that a public hearing be held before a facility can voluntarily close to assess the impact of the closure on the nursing home community and the community at large.
7. Pursue sanctions as required under 42 CFR 488.446 against the nursing home administrator if he or she fails to comply with the state and/or federal closure requirements and make necessary changes in state law to hold owners accountable.

⁶ “State” encompasses the State Legislature, Licensing/Regulatory agency, Medicaid Agency, State Administration

Recommendations Addressing Obstacles to a Successful Transition⁷:

1. Introduce and pass laws permitting residents to be admitted to the first available bed in the facility of their choice and to move to a temporary location until a bed opens up.
2. Require facilities to document, in writing, the reasons for not wanting to accept a resident and work with them to find a solution.
3. Work with the relocation team to identify an appropriate placement that is to the satisfaction of the resident.
4. Establish a real time list of open beds in the surrounding area of the facility that is closing and have it accessible to the relocation team.
5. Develop a uniform notice to be sent by providers to all residents and family members that includes: the reason for the closure, the specific steps the facility will take to close, the rights that residents have to choose a new home, the name and contact information of the local ombudsman and the contact information for filing complaints.
6. Require that a letter/notice from the relocation team or from the State Ombudsman, be sent to all residents and family members at the same time the provider is required to send them a notice. The letter/notice from the Ombudsman must explain the closure process and the rights that residents have, including the right to choose their new home.
7. Coordinate discharge planning from an independent planner if a determination is made that the planning is inadequate. The cost should be borne by the closing facility.
8. When the State survey agency finds that the closing facility does not take into consideration the needs, choice, and best interest of each resident as part of the closing planning and implementation process, it should issue a deficiency citation and require the facility to take immediate steps to remedy the situation.
9. Require that the relocation team meet regularly with and provide written updates on the status of the closure to residents and families.
10. Require a facility to remain open until all residents are transferred to an appropriate location of their choosing. If the state believes that the facility must close due to poor care, or the owner runs out of funds, the state must take over the facility through a receivership or if the state does not have a receivership statute, it must bring in a management company (paid for by the closing facility) or use the federal temporary management remedy in federal law.
11. Ensure continued Medicare and/or Medicaid payments until residents are successfully relocated.
12. Require the closing facility to report staffing on each shift each day to make sure they have adequate staff to care for the residents.
13. Require the closing facility to hire contract staff if needed.

⁷ Many of these recommendations addressing obstacles were suggested by respondents to the questionnaire who were experienced with nursing home closures.

14. Notify the state Department of Labor to help staff with filing for unemployment, writing resumes, etc.
15. Consider a tax on ownership licenses to fund a staffing account that might give bonuses to staff that remain until closure.
16. Encourage facilities to hold job fairs for staff of closing facilities.
17. Require all facilities to train staff on transfer trauma.
18. Require the receiving facility to develop a plan to minimize transfer trauma for residents being admitted from the closing facility.

RECOMMENDATIONS FOR *LONG-TERM CARE OMBUDSMEN*

General Recommendations:

1. Educate all ombudsman program representatives on state and federal closure rules.
2. Develop a formal written protocol for closure detailing the role of the state and local ombudsmen and how they will work with other state agencies.

Recommendations Addressing Obstacles to a Successful Transition⁸:

1. Check records of those residents being refused admittance to make sure they are up-to-date so potential facilities or locations can make an accurate assessment.
2. Urge refusing facilities to interview and assess the resident themselves to accurately determine whether they can meet the resident's needs.
3. File a discrimination complaint with the Civil Rights Division of the U.S. Department of Health and Human Services and/or your state civil rights division if applicable if you feel that a resident is being discriminated against on the basis of his/her disability.
4. Share information with residents and families detailing:
 - a. What should be included in appropriate discharge planning.
 - b. Residents' rights throughout the closure process.
 - c. Where to file a complaint or get help.
 - d. Information on how families can help prevent or minimize transfer trauma in residents.
 - e. Residents' rights, including but not limited to the right to have needs and choice taken into consideration; receive appropriate discharge planning; and be included in discharge planning.

⁸ Many of these recommendations addressing obstacles were suggested by respondents to the questionnaire who were experienced with nursing home closures.

5. Designate a member of the State Ombudsman Office as a relocation specialist to coordinate ombudsman activities related to the closure; train, mentor, and assist local ombudsmen on closures; and oversee closures and certain relocations that might cause resident distress or disorientation.
6. Develop a letter for residents and families describing the closure process, explaining rights and giving ombudsman contact information. This letter should be sent to all residents and families members of the closing facility at the same time the provider announces the closure.
7. Meet one-on-one with each resident or family member to discuss the closure process and their rights either as part of the relocation team or separately. Bring together residents and families in a group with all state agencies to discuss the closure, residents' rights, and to answer any questions.
8. Advocate for facility to remain open until all residents have been relocated to an appropriate location of their choosing.
9. Urge the passage of legislation permitting long-term care ombudsmen to file a request for receivership.
10. Advocate with the corporation of the closing facility (when applicable) for staff to be hired at sister facilities.
11. Advocate with nursing home administration to provide staff with a list of employment resources.
12. Develop in-service training for staff on transfer trauma with input from residents.
13. Create a list of tips for what staff and family can do to help alleviate transfer trauma.
14. Conduct follow-up visits after the relocation to see how residents are doing and provide continuity to residents.
15. Determine the facility's process for tracking residents' belongings to ensure they are moved to the new location with the resident.

QUESTIONS FOR FUTURE RESEARCH

There continue to be stories reported relating to challenging nursing home closures, including a recent example in which a New York nursing home was closed, without notice to the State, in order to repurpose the land on which the nursing home sat for luxury housing⁹. Continued examples raise additional questions that should be addressed by future research.

⁹ <http://www.wnyc.org/story/nursing-home-de-blasio-flouted-state-rules/>.