

NOT FORGOTTEN: PROTECTING AMERICANS FROM ABUSE AND NEGLECT IN NURSING HOMES

Hearing held March 6, 2019

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The above organizations would like to thank Chairman Grassley and Ranking Member Wyden for holding the March 6 hearing, “Not Forgotten: Protecting Americans From Abuse and Neglect in Nursing Homes.” No one who heard Patricia Blank recount the extreme dehydration and subsequent death of her mother in an Iowa nursing home and Maya Fischer talk about the brutal rape of her mother in a Minnesota facility during this hearing will ever forget their stories. The horrific suffering of both nursing home residents and that of others calls for a serious examination of how to combat and end nursing home abuse and neglect. As consumer advocates representing the experiences and interests of nursing home residents nationwide, we take this opportunity to offer recommendations for preventing or addressing abuse and neglect of residents and to respond to statements and testimony made during the hearing.

Abuse and neglect of nursing home residents occurs far too often. They are at increased risk due to the prevalence of dementia and dependency on caregivers for personal care. The systems designed to protect residents and hold facilities and perpetrators accountable have not been as effective as they should be.

Strong, clear actions need to be taken immediately to protect residents and prevent others from suffering the same indignities and fate as the mothers of Patricia Blank and Maya Fischer. To that end, we offer the following recommendations.

I. RECOMMENDATIONS

1. Congress should oppose any weakening of resident protections by urging the Centers for Medicare and Medicaid Services (CMS) to retain the Requirements of Participation for Long-Term Care Facilities as issued in October 2016.

In October 2016, CMS published revised federal nursing home regulations that had been developed over a four-year process of listening to consumers, nursing home providers, and health care experts, including formal notice and comment.¹ These regulations include important new standards that better protect vulnerable individuals and reduce the likelihood of resident harm, such as robust requirements for staff training and prevention, reporting and responding to abuse, neglect and exploitation.

CMS has indicated its intention to change these already revised and improved nursing home regulations in order to reduce the supposed burden on nursing home operators. This would be a mistake; the protections in the current regulations are sorely needed. Nursing home residents as a whole are more vulnerable than when the nursing home regulations were first released in 1991. Residents' acuity level has increased, and the majority have some form of dementia. The increased prevalence of physical and cognitive impairments makes residents more at risk of abuse and neglect, as evidenced by the CNN investigative report that exposed widespread sexual assault in nursing homes across the country, including the rape of Maya Fischer's mother.² In addition, poor care, abuse, and neglect continue to be a problem nationwide as documented by studies and reports.³

The 2016 rules respond to these issues and safeguard residents. For instance, as noted above, there are stronger protections related to abuse, neglect and exploitation. In addition, facilities must annually assess the needs of residents and determine what resources, including numbers, types and competency levels of staff, are necessary to provide the required care and services.

2. Congress should call on CMS to: (1) reverse the decision to set per-instance, rather than per-day, Civil Monetary Penalties as the default financial remedy for violations; and (2) end the persistent under-identification of resident harm in nursing homes.

During the hearing, Dr. Goodrich testified that there are a range of enforcement sanctions, including Civil Monetary Penalties (CMPs) which CMS can impose when a facility is not in compliance or serious abuse has been verified. However, although CMS theoretically has a wide range of enforcement remedies, actual use of these remedies has been relatively narrow. One of the major reasons for inadequate enforcement is the failure to appropriately assign "scope and severity" levels. Most deficiencies are assigned a "no harm" severity level. In fact, in 2015 only 3.4% of all health violations

¹ Federal Register, Vol 81, No. 192, October 4, 2016, 42 CFR Parts 405, 431, 447, 482, 483, 485, 488, and 489

² Blake Ellis and Melanie Hicken. Sick, Dying and Raped in America's Nursing Homes. CNN Reports. February 22, 2017.

³ *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* (Feb. 2014) OEI-06-11-00370. *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2009-2015*. Prepared by: Charlene Harrington, Ph.D. Helen Carrillo, M.S. University of California San Francisco and Rachel Garfield Kaiser Family Foundation

were identified as having caused any harm to a resident, despite the documented evidence on survey reports frequently showing otherwise.⁴ The scope and severity levels are critical because they determine the enforcement remedies that can be imposed – and a no-harm level rarely leads to **any** enforcement action, let alone a **meaningful** enforcement action.

Inadequate nursing home oversight is further weakened by policy changes that CMS has already implemented. Many of these changes correspond to requests from the nursing home industry and were made without public notice or comment. In November 2017, CMS placed an 18-month moratorium on major enforcement of several key regulations that became effective that same month. Other changes lead to lower and less frequent fines. Examples include:

- Making per instance CMPs the recommended remedy rather than per diem fines in all but a few limited circumstances. The result is generally lower penalties imposed for noncompliance.
- Allowing CMPs to be optional instead of mandatory when Immediate Jeopardy does not result in serious injury, harm, impairment, or death.
- Changing how remedies are selected and factors to consider giving CMS Regional Offices (ROs) discretion. For instance, ROs can take into consideration whether the cited noncompliance is a one-time mistake or accident.

These changes are counterproductive. The threat of fines is a critical deterrent to abuse and substandard care, particularly when they are large enough to impact a facility's actions. Yet policy revisions are already having an effect: the average fine is now \$28,405 compared to \$41,260 in 2016.⁵

3. Congress should pass legislation requiring a minimum staffing standard of at least 4.1 hours of direct care nursing time per resident per day.

The relationship between staffing levels and quality of care has been well established. When there is not enough staff, residents suffer physically. They experience painful pressure ulcers, malnutrition, dehydration, infections, preventable hospitalization, injuries, and more. Severe lack of staff, when combined with stress and burnout, are factors that can lead to neglect and abuse.⁶

Insufficient staffing occurs because federal law requires no minimum staffing standard for nursing homes. Medicaid and/or Medicare certified facilities must have “sufficient staff” to meet residents’ needs, but this provision is vague and ambiguous. The lack of specificity means that the decision about staffing levels is up to individual nursing homes. Facilities often cut staffing to maximize profits.

A 2001 study by the federal government determined that a nursing home resident needs at least 4.1 hours of care per day: 2.8 hours from nursing assistants, 0.55 hours from licensed practical nurses, and 0.75 hours from registered nurses.⁷ This is the minimum amount of care needed to prevent common quality of care problems like pressure ulcers, dehydration, and losing the ability to carry out daily tasks

⁴ Safeguarding NH Residents & Program Integrity: A National Review of State Survey Agency Performance, LTCCC (2015)

⁵ Jordan Rau. Trump Administration Cuts the Size Of Fines For Health Violations In Nursing Homes. Kaiser Health News. March 15, 2019.

⁶ Catherine Hawes, Ph.D. Elder Abuse in Residential Long-Term Care Settings: What Is Known and What Information Is Needed? National Academy of Sciences 2003.

⁷ Abt Associates for U.S. Centers for Medicare and Medicaid Services, “Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes.” December 2001.

like eating, dressing, and walking. *As of December 2018, U.S. nursing homes provided an average of only 3.5 total care staff hours per resident per day, significantly below the recommended 4.1 hours.*⁸

4. Congress should ban the use of pre-dispute arbitration agreements in nursing homes.

A pre-dispute arbitration agreement in a nursing facility is signed by a resident during the admissions process, when he or she will know nothing about any future dispute that may be subject to the arbitration agreement. Generally, residents or their family members sign these agreements because they feel that they have no choice, and during times of great stress and confusion.

Pre-dispute arbitration agreements are inherently unfair and dangerous for consumers. They lessen nursing facility accountability by forcing residents into secret proceedings when seeking redress. This hides allegations of abuse, neglect and poor care from the public and regulators, which diminishes the consequences of negligent care by providing cover for poorly performing facilities. Fewer consequences can allow substandard care to continue, leading to more, not fewer, injuries, and greater costs to taxpayer-funded programs like Medicare. Civil court cases help deter bad actors, thereby protecting residents.

Congressional action is needed. The 2016 regulations include a provision barring pre-dispute arbitration, but the government declined to appeal preliminary injunctive relief in a Mississippi federal court that barred the enforcement of the regulation.⁹ Subsequently, CMS proposed a regulation that not only would allow pre-dispute arbitration agreements but would, for the first time, explicitly permit nursing facilities to require pre-dispute arbitration agreements as a condition of admission.¹⁰

5. Congress should (1) update minimum funding and maintenance of effort provisions for the State Long-Term Care Ombudsman Program in the reauthorization of the Older Americans Act (OAA) to reflect the most current fiscal year; and (2) increase the current OAA Title VII State Long-Term Care Ombudsman Program authorized funding level to \$35 million.

Under the federal Older Americans Act (OAA), every state is required to have a State Long-Term Care Ombudsman Program (LTCOP) that addresses complaints and advocates for improvements in the long-term care system. Each state has an Office of the State Long-Term Care Ombudsman, headed by a full-time State Long-Term Care Ombudsman who directs the program statewide. Trained individuals designated as ombudsman representatives by the State Ombudsman directly serve residents.

Among other duties, long-term care ombudsmen investigate and seek to resolve complaints made by or on behalf of residents of long-term care facilities. This includes complaints about abuse. Ombudsmen are directed by what the resident wants and must adhere to strict confidentiality laws. Depending on the situation and resident consent, ombudsmen may make a referral to the appropriate protective service, regulatory, or law enforcement entity and/or pursue a range of advocacy strategies with the

⁸ Long Term Care Community Coalition News Alert: Latest Data Indicate Low Staffing Is Persistent & Pervasive. February 2019.

⁹ *Am. Health Care Ass'n v. Burwell*, 217 F. Supp. 3d 921 (N.D. Miss. 2016).

¹⁰ 82 Fed. Reg. 26,649 (2017).

goal of doing as much as the resident wants them to be do. Ombudsmen may also provide training to facility staff on abuse prevention.

The LTCOP, in many states, struggles to provide residents with regular access to help due to insufficient funding. LTCOPs are stretched so thin because funding has not increased significantly in the last decade. Many programs have not recovered from funding cuts that occurred beginning in 2008. This means that many residents cannot receive the advocacy, assistance and support they need to obtain quality of care and quality of life.

- 6. Congress should: (1) request a GAO study into the financing of long-term care facilities, specifically looking at how federal funds are used; and (2) pass legislation requiring (a) audits of cost reports, (b) transparency through detailed financial reporting that includes disclosure of finances regarding related-party companies and owners, (c) limits on how much money in administrative costs a nursing home can claim and how much profit they can make from those public funds, and (d) any additional dollars allocated for Medicare and/or Medicaid funding for nursing homes be spent on direct care only.**

Under the Nursing Home Reform Law, one of the duties of the Secretary of Health and Human Services is to “promote the effective and efficient use of public moneys.”¹¹ Yet neither the Secretary, government officials nor the public know whether Medicare and Medicaid dollars are being spent appropriately and responsibly. Medicare does not audit financial cost reports, and financial reports do not reveal the hidden profits, such as inflated payments for management, pharmacy, staffing and therapy services made to other companies owned by the same persons or entities who own the facility.

In addition, there are no requirements for how nursing homes spend federal funding. Some nursing home operators disproportionately use public dollars to pay for salaries, administrative costs, and other non-direct care services.¹² For instance, the New York State Attorney General recently filed a complaint against an operator, alleging that the operator diverted Medicaid funds away from residents and “paid such monies for their own benefit through companies they owned or controlled.”¹³ An article in *The New York Times* reports that related-party transactions have become a “common business arrangement, [as] owners of nursing homes outsource a wide variety of goods and services to companies in which they have a financial interest or that they control.”¹⁴

- 7. Congress should pass legislation regarding corporate accountability that requires CMS to: (1) establish minimum federal criteria for assuming ownership or management of Medicare**

¹¹ 42 U.S.C. § 1395i-3(f)(1)

¹² Medical Loss Ratios for Nursing Homes: Protecting Residents and Public Funds. Joint Statement from the Center for Medicare Advocacy and the Long Term Care Community Coalition.

¹³ Ex-owners of nursing home face felony charges. *The Daily Star*. Denise Richardson. June 7, 2018.

¹⁴ Care Suffers as More Nursing Homes Feed Money Into Corporate Webs. *New York Times*. Jordan Rau. January 2, 2018. Christopher H. Schmitt. *The New Math of Old Age: Why the nursing home industry’s cries of poverty don’t add up*. Investigative Report. *U.S. News & World Report*. September 30, 2002.

and/or Medicaid funded nursing homes; and (2) deny or revoke a facility's Medicare enrollment if an owner is affiliated with a previously revoked facility.

There is a growing number of acquisitions/mergers/deals in which large numbers of nursing homes are taken over by corporations, with little to no scrutiny of the corporations' financial capacity or experience and/or history of providing care.

- Nursing home chains can sell their homes to companies with a track record of poor care. This is exactly what happened when Avante, a Florida-based nursing home chain, sold its North Carolina nursing facilities to SentosaCare. SentosaCare had a history of substandard care, with large numbers of violations.¹⁵
- Corporations buying facilities may have no previous experience in running nursing homes. Skyline was considered an "unknown firm," while the *Philadelphia Inquirer* noted the general lack of information about the company.¹⁶
- Owners with a seriously troubled history are permitted to start a new company and repeat the history. For example, in the mid-1990s, there had been bankruptcy and sudden closings in facilities owned by Jon Robertson.¹⁷ However, in 2006 he started a new company, Utah-based Deseret Health Group, which went on to experience the same problems.¹⁸
- Owners are allowed to buy or sell nursing homes even if they are in financial distress. When Skyline took over 18 nursing homes in South Dakota, it was already struggling to pay its bills in other states. In Kansas where Skyline had 15 facilities, the executive director of the Kansas Health Care Association stated, "I honestly don't believe the Skyline people had a year's worth of working capital."¹⁹

The failure to assess whether owners and managers are qualified and competent is harming residents, who may have to relocate if their facilities are forced to close following bankruptcy. The resulting transfer trauma experienced by many residents can lead to physical, mental, and emotional decline, and sometimes even death. The federal government needs to establish standards to ensure that individuals and companies who have such an impact on resident health and safety are capable and fit to do so.

8. Congress should make the National Background Check Program mandatory.

¹⁵ Richard Craver, "Avante plans to sell six NC nursing homes, including three in Triad," *Winston-Salem Journal* (Apr. 18, 2018).

¹⁶ Maggie Flynn, "Troubled Skyline Highlights Problems with Under-the-Radar Skilled Nursing Operators," *Skilled Nursing News*, April 12, 2018.

¹⁷ Eric Slater, "Entrepreneur Fades From View as Empire Collapses; Business: Critics say owner of shuttered nursing homes, including one in Reseda, lived lavishly amid unpaid bills," *Los Angeles Times* (Oct. 23, 1997).

¹⁸ H.B. Lawson, "Nursing home faces closure; Deseret Health Group closing facilities in several states, Saratoga facility put on chopping block Friday," *The Saratoga Sun* (May 6, 2015).

¹⁹ Kelsey Ryan and Andy Marso, "How a small company above a N.J. pizza parlor put Kansas nursing home residents at risk," *The Kansas City Star*, April 15, 2018.

Current background check systems do not adequately protect nursing home residents from exploitation and abuse. A 2011 report by the Office of the Inspector General (OIG) found that 92 percent of nursing facilities employed at least one individual with at least one criminal conviction.²⁰ Additionally, nearly half of nursing facilities employed five or more individuals with at least one conviction.²¹ Most convictions were for property crimes (e.g., burglary, shoplifting, writing bad checks), and an alarming number of convictions were for crimes against persons, including sex crimes. The same report found that only ten states require both an FBI and a statewide criminal background check for prospective employees. This means that in many states, prospective employees' out-of-state convictions go undetected and those with records of abuse are often hired by nursing facilities.²²

The National Background Check Program (NBCP) was created to address these problems. It is a **voluntary** program that provides non-competitive grants to states in order to help them implement and improve employee background check systems in long-term care facilities. The program is administered by the Centers for Medicare and Medicaid Services (CMS) in consultation with the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI).

A 2016 DHS report found that 25 states have participated in the program. It also found that the NBCP screened out 30,025 individuals with a history of patient abuse or a violent criminal background through September 30, 2014.²³ Congress should build on this program's success and make it mandatory so residents in all states receive this important protection.

II. RESPONSE TO WITNESS TESTIMONY

In addition to the above recommendations, we find it necessary to comment on issues raised by some of the witnesses and their answers to questions during the hearing. Specifically:

Medicaid reimbursement

During the hearing, Dr. David Grabowski testified that the Medicaid rate was too low and "you get what you pay for." He indicated that rural nursing homes were closing because the Medicaid reimbursement rates were inadequate and cited the *New York Times* article²⁴ that focused on the closing of Mobridge Care and Rehabilitation Center in South Dakota.

Before concluding that the Medicaid rate is too low, we urge Committee members to consider three points. First, as noted earlier, the amount of money nursing homes allocate to administrative costs and profits, instead of care, is not known. This could mean that the problem may be how nursing homes choose to spend their Medicaid dollars, rather than lack of sufficient money. For this reason, we urge Congress in recommendation #5 to request a GAO study into the financing of long-term care facilities, specifically looking at how federal funds are used.

²⁰ Department of Health and Human Services, Office of the Inspector General, *Nursing Facilities' Employment of Individuals with Criminal Convictions* (2011).

²¹ Ibid.

²² Ibid.

²³ Department of Health and Human Services, Office of the Inspector General, *National Background Check Program for Long-Term-Care Employees: Interim Report* (2016).

²⁴ Jack Healy. Nursing Homes Are Closing Across Rural America, Scattering Residents. *The New York Times*. March 4, 2019.

Second, more money does not necessarily mean better quality care. Despite Medicare reimbursement rates of approximately \$550 or more per day, a Department of Health and Human Services Office of Inspector General investigation found that 1/3 of Medicare beneficiaries receiving skilled nursing facility services experienced harm within 16 days of admission, and almost 60% of that harm was determined to be preventable.²⁵

Third, Skyline's takeover of Mobridge and the corporation's subsequent failing may have been a significant factor in the closing of the facility. At the beginning of 2017, Mobridge was bought by Skyline Healthcare Inc. By April 2018, a divisional vice president in charge of Skyline facilities in South Dakota sent emails to the South Dakota Department of Health stating that employees across the group in the state had not been paid, and the facilities only had enough housekeeping and laundry supplies for four more days of operation, and food for residents for five more days.²⁶ In May, the state put a receiver in place, but by November the receiver petitioned for Mobridge's closure, claiming significant and unsustainable losses.²⁷ A similar pattern could be seen in Skyline facilities elsewhere, for example in Nebraska and Kansas, where states sought court-approved receiverships or otherwise took over the nursing homes in order to assure that residents would continue to receive food, medicine and care.²⁸

Nursing Home Compare and the Five-Star Rating System

We are concerned that the many comments and questions about the accuracy of Nursing Home Compare and the Five-Star Rating system at the hearing indicate an over-reliance on data in consumer selection of nursing homes.

While improvements are needed, Nursing Home Compare and the Five-Star Rating System are not a fool-proof indication of a nursing home's quality. Consumers must be encouraged to use other factors, such as onsite visits, whenever possible in evaluating a facility. Conditions in long-term care facilities can change so rapidly that the information reported may already be out-of-date, particularly if there has been a change in the administrator or director of nursing, or if the facility has recently been bought by a corporation.

Additionally, when CMS implemented a revised survey process on November 28, 2017, the agency imposed a freeze on health inspection data used to calculate the health inspection star rating. As a result, the most recent inspection has not been included in the five-star rating system. While the freeze is scheduled to end in April 2019, prospective residents and their family members researching facilities during this time period have received incomplete information.

²⁵ *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* (Feb. 2014) OEI-06-11-00370. *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2009-2015*. Prepared by: Charlene Harrington, Ph.D. Helen Carrillo, M.S. University of California San Francisco and Rachel Garfield Kaiser Family Foundation

²⁶ Bart Pfankuch, Wave of SD nursing home closures hitting hardest in rural small towns. *The Brookings Register*. March 17, 2019.

²⁷ *Ibid.*

²⁸ Toby Edelman. *Buying and Selling Nursing Homes: Who's Looking Out for the Residents?* Center for Medicare Advocacy.

Unfortunately, too many consumers have such limited choices of nursing homes that information about quality is often moot. Consumers and families seeking a nursing home after hospitalization are frequently given very limited time to decide about a long-term care facility, and/or may be directed towards a facility with which there is a referral arrangement with the hospital. Additionally, a growing number of consumers in Medicaid managed care plans have little to no choice of nursing homes (as of 2017, 24 states had Medicaid Long-Term Services and Supports programs²⁹), while others are limited by geographical or other constraints.

Improvement in quality care

In his testimony, Dr. David Gifford said that the quality of nursing home care has improved dramatically. Nevertheless, the following data show that quality is still elusive for too many nursing facilities:

- Almost 21 % of nursing homes received a deficiency at the level of harm or immediate jeopardy³⁰
- 42% of nursing homes had either a one-star or two-star rating for health inspections³¹
- 42% of nursing homes had chronic deficiencies three years in a row³²
- 20% of nursing home residents - approximately 250,000 individuals - are administered antipsychotic drugs that are life-threatening³³
- 7.5% of nursing home residents - approximately 95,000 individuals - have unhealed pressure ulcers even though research shows that almost all pressure ulcers are preventable³⁴
- A 2014 US Office of Inspector General (OIG) report found that 33% of Medicare residents experienced adverse events or harm within 16 days of admission to a skilled nursing facility. Almost 60% of the harm was determined to be avoidable.³⁵

Nursing Home Regulations

²⁹ Elizabeth Lewis, Steve Eiken, Angela Amos, Paul Saucier. The Growth of Managed Long-Term Services and Supports Programs: 2017 Update. January 29, 2018. Truven Health Analytics.

³⁰ Charlene Harrington, Ph.D., Helen Carrillo, M.S. University of California San Francisco. Rachel Garfield, MaryBeth Musumeci, Ellen Squires, Kaiser Family Foundation. Nursing Facilities, Staffing, Residents and Facility Deficiencies: 2009-2016. April 2018.

³¹ CMS Provider data, Processing date: February 1, 2019.

³² Chronic Deficiencies in Care: The Persistence of Recurring Failures to Meet Minimum Safety & Dignity Standards in U.S. Nursing Homes. Long Term Care Community Coalition. 2017.

³³ Long Term Care Community Coalition News Alert November 2018: Latest Data on Nursing Home Antipsychotic Drugging. 2018Q2 MDS Data (N0410A: Medications - Medications Received – Antipsychotic).

³⁴ Safeguarding NH Residents & Program Integrity: A National Review of State Survey Agency Performance, Long Term Care Community Coalition. 2015.

³⁵ Adverse Events in Skilled Nursing Facilities, DHHS OIG, February 2014

Since January 2017, CMS has systemically worked to rollback resident protections through proposed revisions of current regulations. Dr. Kate Goodrich stated in her testimony that this relaxing of rules was aimed at “paperwork and administrative requirements” that “may be getting in the way of patient care.”

The changes CMS is pursuing cannot be characterized as focused just on “paperwork.” In addition to reversing the ban on arbitration agreements described earlier, here are examples of what the agency is targeting:

- **Development of care plans for residents within 48 hours of admission.** Nursing home residents have significant care needs, and appropriate care must be provided from the first day. To protect residents during their vulnerable first days in the facility, the federal government in 2016 strengthened care planning regulations. Elimination of these requirements could lead to poor care, injury and death.
- **Reporting serious bodily injury due to abuse or neglect within 2 hours.** Delayed reporting reduces the chances of providing prompt assistance to abuse victims and finding forensic evidence. The 2016 regulations addressed this problem by mandating that severe harm be reported within two hours. However, this timeframe for reporting may now be extended. Permitting additional time before severe harm is reported means residents may not get help quickly enough and preserving vital evidence in an investigation may be jeopardized. Lessening any requirements related to abuse reporting leaves residents at greater risk of abuse.
- **Protections against evictions.** Across the country, nursing homes are discharging residents against their will and sending them to inappropriate and unsafe settings, such as homeless shelters. Residents who are kicked out like this can experience harm and may never recover. To better protect residents from improper evictions, the 2016 regulations require nursing homes to notify local ombudsman programs whenever a nursing home moves to evict a resident. Long-term care ombudsmen are advocates for nursing home residents. When ombudsmen are notified, they can contact the resident and/or representative and provide assistance if requested. Most of the time ombudsmen are successful in resolving a problem or concern that has triggered the proposed discharge, thereby reducing inappropriate discharges. This notification requirement may be eliminated or modified, leaving residents without much needed assistance.

Conclusion

The organizations listed at the beginning of this statement thank the Committee for bringing attention to the care and treatment of our country’s nursing home residents, who, too often, feel as if they are invisible and forgotten. The failure to address long-standing problems, and current and possibly future rollbacks of protections, are sending a strong message to residents that they are also being abandoned. We stand ready to help the Committee ensure that residents are not forgotten, and that nursing home safety and oversight are strengthened, not weakened.