

**EXAMINING FEDERAL EFFORTS TO ENSURE QUALITY OF CARE
AND RESIDENT SAFETY IN NURSING HOMES**

**House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations Hearing
September 6, 2018**

STATEMENT OF THE NATIONAL CONSUMER VOICE FOR QUALITY LONG-TERM CARE

The National Consumer Voice for Quality Long-Term Care (Consumer Voice) commends the U.S. House Subcommittee on Oversight and Investigations for holding a hearing today entitled, “Examining Federal Efforts to Ensure Quality of Care and Resident Safety in Nursing Homes.”

Consumer Voice is a national non-profit organization that advocates on behalf of long-term care consumers across care settings. Our membership consists primarily of individuals receiving long-term care and services, their families, long-term care ombudsmen, individual advocates, and citizen advocacy groups. Formed more than 40 years ago out of concerns about substandard care, abuse and neglect, Consumer Voice was instrumental in the passage of the 1987 Nursing Home Reform Law, which established a system of identical standards for Medicare-reimbursed services and Medicaid-reimbursed services, to ensure that every resident receives high-quality care and is able to live with dignity. Important additional provisions have been added to the law since then, notably in the Affordable Care Act. Staffing adequacy has become an increasing focus with the advent of the Payroll-Based Journal (PBJ) system, which requires facilities to report staffing based on auditable data.

While there are certainly nursing homes that provide excellent care, studies and reports show that poor care, abuse and neglect continue to be a problem nationwide. For instance:

- The U.S. Department of Health and Human Services Office of Inspector General (OIG) report released in 2014 found that approximately one-third of individuals discharged from a hospital to a skilled nursing facility were harmed, and that 59% of the time that harm was “clearly or likely preventable.”¹
- In 2016 approximately one in five nursing homes had violations that caused harm or immediate jeopardy (defined as causing or likely to cause injury, harm, impairment, or death to a resident).²

¹ *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* (Feb. 2014) OEI-06-11-00370

² *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 2009-2016*. Prepared by: Charlene Harrington, Ph.D. Helen Carrillo, M.S. University of California San Francisco and Rachel Garfield, MaryBeth Musumeci, and Ellen Squires Kaiser Family Foundation

The National Consumer Voice for Quality Long-Term Care (formerly NCCNHR) is a 501(c)(3) nonprofit membership organization founded in 1975 by Elma L. Holder that advocates for quality care and quality of life for consumers in all long-term-care settings.

- After reviewing investigation reports from 2013-2016, CNN Investigations found that the federal government had cited more than 1,000 nursing homes for mishandling or failing to prevent alleged cases of rape, sexual assault and sexual abuse at their facilities during this period. And nearly 100 of these facilities had been cited multiple times during the same period.³
- Nearly 20% of nursing home residents – over 250,000 individuals – are currently receiving antipsychotic medications.⁴

These data and the experiences of residents and their families around the country point to a failure on the part of the federal government to ensure quality of care and resident safety. At a Senate hearing on nursing home quality in 2003, one of the witnesses, Dr. William Scanlon of the GAO, made the following statement, “I do not believe we have adequately implemented the survey and enforcement process as envisioned in OBRA 1987 and further defined by HCFA [*now CMS*]. The execution of surveys and the enforcement actions that should follow them have been so lacking, we do not know how effective the process can be.”⁵ The same can be said today in 2018. Much more effective oversight and accountability of nursing facilities is needed from the federal and state agencies responsible, and that starts with the Centers for Medicare and Medicaid Services.

Inadequate Enforcement

The Consumer Voice has long been concerned about CMS’ weak enforcement of the Requirements of Participation - the standards of care related to residents’ health, safety, welfare, and rights. There are numerous reasons for this ineffective oversight.

Failure to appropriately assign scope and severity

A long-standing and increasing concern is that the vast majority of deficiencies are assigned a “no harm” level of scope and severity. In fact, in 2015 only 3.4% of all health violations were identified as having caused any harm to a resident, despite the documented evidence on the survey reports themselves showing otherwise.⁶

Below is just one example of a deficiency that was considered to be a no-harm level despite the pain the resident suffered:

State surveyors cited the nursing home for an F-309 deficiency (42 C.F.R. § 483.25)— “[p]rovide necessary care and services to maintain the highest well-being of each resident.” The facility’s policy regarding pain management provided that residents receive management through an interdisciplinary team evaluation. The policy also required that a resident’s physician must be notified if the resident continues to experience pain, despite medication or non-pharmacological interventions. The resident in this case was admitted to the nursing home on April 8, 2017. 7 On September 6th, a nurse documented that the resident had developed “softening and breakdown of skin

³ Sick, Dying and Raped in America’s Nursing Homes. Blake Ellis and Melanie Hicken CNN Investigations.

⁴ Safeguarding NH Residents & Program Integrity: A National Review of State Survey Agency Performance, LTCCC (2015), <http://nursinghome411.org/naWonal-report-safeguarding-nursing-home-residents-program-integrity>

⁵ Nursing Home Quality Revisited: The Good, The Bad, and The Ugly. Hearing Before the Committee on Finance, United States Senate, 108th Congress, July 17, 2003.

⁶ Safeguarding NH Residents & Program Integrity: A National Review of State Survey Agency Performance, LTCCC (2015), <http://nursinghome411.org/naWonal-report-safeguarding-nursing-home-residents-program-integrity>

resulting from prolonged exposure to moisture.” The resident’s left and right buttocks were the affected regions. While reviewing the resident’s records, surveyors saw that the physician had ordered, in part, that the resident get sleep and 650mg of Tylenol arthritis every 12 hours. The resident told surveyors that “[i]t’s like pulling teeth to get something for pain around here. My bottom hurts terribly.” During the interview, surveyors observed the resident grimacing when repositioning herself. When the surveyors interviewed the DON, it became clear to them that the facility had no evidence that it contacted the resident’s physician about her “uncontrolled” pain. The surveyors cited the nursing home for the deficiency, but despite the resident’s uncontrolled pain, surveyors assessed the deficiency as “no harm.”⁷

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 actions, let alone **meaningful** enforcement actions.

Consumer Voice, along with other advocates, has raised this problem of no harm citations repeatedly with CMS officials. In the past year we were assured by CMS that a new survey process with revised guidance to surveyors that includes new detailed information on how to assess scope and severity would address this problem. To-date we continue to see deficiencies inappropriately assigned a scope and severity level of no harm. Alarming, the percentage of no harm violations related to use of psychotropic medications has actually decreased, with 99.5% of nursing home violations for misuse of psychoactive drugs (as of 8/27/2018) classified as non-harmful to residents.

Failure to use enforcement remedies effectively

When sanctions are imposed, they are often too minimal to have a deterrent effect. This is particularly the case with the most commonly used sanction, civil monetary penalties. A GAO study (2005) found that CMS does not utilize the full dollar range allowed for civil monetary penalties. Instead, fines tend to be toward the lower ends of the ranges.⁸ This is still true today. A recent example from Connecticut (2018) illustrates how small many fines often are, particularly when compared to the harm caused to the resident:

A Stamford nursing home was fined \$6,000 after a resident died. The resident had been found sitting on the floor. Video footage at the facility showed staff had not opened the door to the resident’s room or checked on the resident between 6:26 p.m. on Feb. 15 and 5:19 a.m. on Feb. 16. Staff did not begin CPR on the resident until 10 minutes after the resident was observed by a licensed practical nurse to have no pulse. The resident was taken to a hospital and later pronounced dead.⁹

⁷ *Elder Justice Newsletter: What “No Harm” Really Means for Residents*, vol. 1, issue 2, a publication of the Center for Medicare Advocacy and the Long Term Care Community Coalition, December 2017
<http://www.medicareadvocacy.org/wp-content/uploads/2018/01/Elder-Justice-Newsletter-Dec.-2017-00279924xC6348.pdf>

⁸ Nursing Home Enforcement: The Use of Civil Monetary Penalties. Department of Health and Human Services, Office of Inspector General. April 2005.

⁹ <http://c-hit.org/2018/06/13/six-nursing-homes-fined-following-lapses-in-care-2/> June 13, 2018.

Penalties this low are insufficient to deter repeat or continued violations; they must be of an amount to have an impact on the facility and result in sustained compliance. In fact, CMS's State Operations Manual, Chapter 7, gives states guidance on imposing CMPs with the example that if failure to spend money is the root cause of the facility's noncompliance, then any civil money penalty imposed should at least exceed the amount saved by the facility.¹⁰ When poor care costs the facility more than good care, a nursing facility has more incentive to stay in compliance with requirements.

Another effect of insignificant remedies is "yo-yo compliance." Ombudsmen, citizen advocates, and consumers regularly report that, year-after-year, many of the same facilities come in and out of compliance for the same issues. This is supported by a recent analysis showing that 42% of nursing homes have chronic deficiencies—defined as 3 or more—for the same issue for 3 years.¹¹

Not only are individual facilities not being appropriately held accountable for poor care, neither are the corporations that run and/or manage them. Over half of nursing homes belong to some kind of multi-facility chain. Many if not all of the decisions governing staffing and budget that contribute to or cause poor care are made by the corporation. Yet CMS has taken no actions against corporate entities to deter substandard care, nor directed states to put systems in place that ensure corporations with a history of poor performance and/or unstable financing are not permitted to open new facilities or take over existing ones.

This already inadequate enforcement system is now being further weakened by policy changes made by CMS - changes that will result in lower and less frequent fines (Civil Monetary Penalties - CMPs). These changes correspond to direct requests from the nursing home industry and were made without public notice or comment. Examples of these policy changes 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 consider the extent to which the cited noncompliance is a one-time mistake or accident.

These policies are already having an impact. At the beginning of September 2018, the number of per instance fines is now more than double the number of per day fines. The average fine is only \$9,467.37 when calculated as "per instance" compared to \$72,589.45 when calculated according to days out of compliance.¹² Consequently, the monetary penalty a facility must pay

¹⁰ CMS State Operations Manual, Chapter 7 - Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities. Interim Advanced Copy. 7400.4. <file:///C:/Users/Admin/Documents/Enforcement/QSO18-18%20Revisions%20to%20the%20SOM%20Chapter%207.pdf>

¹¹ *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.

¹² QCOR, CMP report, September 3, 2018.

is significantly reduced, creating less incentive for facilities to fix problems quickly or to remain in compliance. This places residents at increased risk of poor care and harm.

Rollback of protections

The standards that are to be enforced are also threatened. The Requirements of Participation were recently revised and issued October 2016. They provide important new protections for residents and will better ensure resident quality of care, quality of life and safety.

The revised rules were years in the making. CMS first began consulting with stakeholders in 2012 and provided multiple opportunities for groups representing a range of interests to express their perspectives and concerns prior to issuing the proposed rule. When released, the proposed regulations received nearly 10,000 comments. CMS carefully reviewed and considered each of these comments. The proposed rules were evaluated and re-evaluated before they were issued.

Yet just a few short months after their release, CMS began undermining and dismantling its own rules. The agency issued a proposed rule to eliminate the ban on forced pre-dispute arbitration; published a request for feedback on whether to eliminate or modify certain requirements - each of which makes an important difference in the lives of residents; and delayed by 18 months any major enforcement of a number of key regulations that were phased in November 2017. Most disturbing of all, CMS has indicated it will issue a new proposed rule to again “reform” the nursing home regulations.

These changes are being put forth under the umbrella of regulatory reform and to “reduce the burden on providers.” However, despite provider claims that the regulations are onerous, unnecessary and micromanage their operations, there is significant flexibility in the rules. Where the language is prescriptive, it is because experience showed that flexibility resulted in inaction by providers and detail was necessary – as evidenced by the addition of rules pertaining to antibiotic stewardship, baseline care plans, a grievance process, and emergency preparedness. Furthermore, many of the requirements that providers point to as “burdensome” are, in fact, important resident protections.

Many of the revisions CMS has mentioned correspond directly to modifications the [nursing home industry has requested](#)¹³ and directly overturn provisions just added the 2016 rules. Some of the provisions had not even been implemented, and others were just in the process of being implemented, yet CMS was already indicating its intent to make changes.

Insufficient staffing

Lack of enough nursing staff -- both licensed nurses and certified nursing assistants -- to provide residents with the care they need, when they need it is the number one complaint Consumer Voice hears from residents and families. Study after study has shown the relationship between staffing levels and quality of care, and the harm residents experience when those staffing levels are not adequate.

¹³ *How CMS is Rolling Back Protections*, <http://www.justiceinaging.org/wp-content/uploads/2018/06/How-CMS-Is-Rolling-Back-Nursing-Home-Protections.pdf>

A landmark federal study in 2001 indicated that a minimum of 4.1 hours of direct care staff time is typically needed to prevent common quality of care problems and loss of the ability to do things independently, like eating, yet approximately one-third of nursing homes report total direct care staffing of 3.0 hours per resident day or less.¹⁴

The major reason for this understaffing is the lack of a 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, or the corporations that control them. The result is that facilities often cut staffing in order to maximize profits.

Rollout of the PBJ database is a welcome development, and CV commends CMS for its close attention to reported staffing levels that are based on auditable data (as opposed to self-reported staffing data, which is unreliable). Data have already shown that staffing levels in many facilities are lower than previously reported¹⁵. We strongly recommend that the agency take further steps to address and correct the evident gaps between what PBJ staffing data are now showing, and the recommended federal standard of 4.1 hours of direct care staff time per resident per day.

Lack of Public Transparency and Accountability

Neither the public nor government officials know exactly how public monies for nursing home care are spent. Medicare does not audit financial cost reports, nor do financial reports reveal the hidden profits taken by owners, such as inflated administrative payments to management, pharmacy, staffing and therapy, and other companies owned separately by the owners.¹⁶ There are no requirements for how much a nursing home can spend on administrative costs or set aside for profits.

Inadequate emergency preparedness

Although time, attention and resources have been devoted to emergency preparedness, and the federal government issued new regulations, these efforts do not go far enough in ensuring that nursing home residents are adequately protected during emergencies and disasters.

There are still dangerous gaps in resident safety. Such gaps include maintaining HVAC systems and power restoration. The complex medical conditions of many residents, and sensitivities of older adults to extreme heat or cold, place residents at risk in power outages. This was all too evident last year in Florida when loss of air-conditioning and power contributed to the deaths of more than 10 nursing home residents in Florida during Hurricane Irma. We applaud the Energy and Commerce Committee’s recent inclusion of Section 4 of the Nursing Home CARE Act (H.R. 4704) in the reauthorization of the Pandemic and All-Hazards Preparedness Act. This section requires states to prioritize nursing homes for power restoration in the same manner as

¹⁴ CMS Payroll-Based Journal staffing data. June 2018

¹⁵ *‘It’s Almost Like a Ghost Town.’ Most Nursing Homes Overstated Staffing for Years*, Jordan Rau, NY Times, July 7, 2018, <https://www.nytimes.com/2018/07/07/health/nursing-homes-staffing-medicare.html>

¹⁶ *Care Suffers as More Nursing Homes Feed Money into Corporate Webs*, Jordan Rau, NY Times, January 2, 2018, <https://www.nytimes.com/2018/01/02/business/nursing-homes-care-corporate.html>

hospitals in All-Hazards Public Health Emergency Preparedness and Response Plans. Changing the power restoration priority system is a very important step to better protecting nursing home residents. However, more remains to be done.

Consumer Voice is also concerned about reports from the field that nursing homes are still not prepared for a natural disaster or major emergency.

Recommendations

To ensure resident quality and safety, Consumer Voice recommends the following:

Regulations

- Retain the Requirements of Participation for Long-Term Care Facilities as issued in October 2016.

Enforcement

- Reverse the changes in enforcement policy
- Create an ongoing technical expert panel to conduct reviews of assignment of scope and severity and recommend changes as appropriate. The panel must consist of at least as many consumers and consumer representatives as provider representatives. The panel will report its findings to CMS and the Subcommittee on Oversight and Investigations on a regular basis.
- Request a GAO study of issues related to scope and severity determinations and enforcement actions.

Financial transparency and accountability

- Ensure Medicaid and Medicare funding is spent appropriately and responsibly by passing legislation that requires:
 - Audits of cost reports
 - Transparency through detailed financial reporting that includes disclosure of finances regarding related party companies and owners
 - Limits on how much money in administrative costs a nursing home can claim and how much profit they can make from those public funds.

Buying, selling, licensing of nursing homes

- Mandate that CMS:
 - Develop procedures to assess the financial stability of purchasers and managers and evaluate their provision of care
 - Require states to enforce those procedures

Emergency Preparedness

- Pass the Nursing Home Care Act, HR 4704. This bipartisan legislation, sponsored by Representatives Wasserman Schultz (D) and Tim Walberg (R) requires nursing homes to

- have an alternate source of power to run heating, cooling and ventilation systems for at least 96 hours and directs states to prioritize power restoration in nursing homes in the same manner as hospitals.
- Require federal surveyors to consult with local emergency preparedness experts in the course of doing inspections of the facility, in order to accurately assess whether the facility is properly prepared for possible disasters and in compliance with federal emergency preparedness standards that apply broadly to health care providers, including SNFs and NFs.

The Consumer Voice applauds the Committee's interest in this important issue and stands ready to provide assistance as the Committee moves forward in its oversight of the nursing home industry.

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