NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM RESOLUTIONS SUMMARY 1986 - 2007

1986

1. Surveyor training needs to include geriatric nursing issues and skills.

2. Training for nurse aides.

3. HCFA needs to accept IoM Social Services recommendation.

4. NCCNHR needs to work to:
   - ш prohibit Medicaid discrimination
   - ш ensure staffing for good care
   - ш ensure nurse aide training
   - ш effective enforcement

1987

1. NCCNHR+ AoA + NASOP to develop national standards for ombudsman practice and training.

2. NCCNHR work to get AoA to fund technical support center for ombudsmen.

1988

1. NCCNHR educate to get reimbursement reform to attain and target money for: direct care, OBRA implementation, other quality care reforms.

2. NCCNHR get HCFA to: develop better survey forms with more information regarding ownerships, deficiencies, indexing, etc. (next part about "hasty, unclear survey release").

1989

1. HCFA improve social services structure, process, etc. to assure resident well-being.

2. Opposes current reimbursement for OBRA; proposes better reimbursement for facilities; better reimbursement for state survey agencies; NCCNHR members to get involved with state plan process.

3. Advocate to get a state to tell ombudsman when nursing waivers are granted.

4. HCFA improve activities services structure, process, etc., to assure resident well-being.

5. PASARR should apply to all residents, not just Medicaid.

6. NCCNHR work for federal legislation to strengthen state licensure programs' ability to pursue remedies.

1990

1. Advocate for postal services to forward mail for nursing home residents like for all other citizens.

2. Advocate for social services to have trained social workers; social workers on survey teams; social services supervision where staff not gerontologically trained.

3. NCCNHR ask HCFA to protect resident identity in citing deficiencies.

4. NCCNHR mission statement be re-written to include board and care language; develop federal standards; educate members on board and care issues.

1991

1. Resident rights week should always begin the first Sunday in October each year.

2. Call on Congress to mandate Medicaid payments for Medicaid recipients who use hospital leave days and to restrict nursing facilities to no more than the State Medicaid payment rate for hospital leave days for non-Medicaid residents. Also, that Medicaid beneficiaries be afforded Medicaid bed-hold privileges, even if Medicare has been the primary or only payor prior to hospitalization.

3. Case-mix components for states with case mix:
   a) Systems should not include a profit or efficiency incentive in the direct resident care or nursing care cost areas. Facilities must not be allowed to use revenue they receive for the direct care of residents to make profits or offset losses in other areas, such as administration. They must be required to use all of their direct care revenue or be required to return the money to the state;
   b) Systems should have programmatic requirements for each case or category residents fall in to. Thus, facilities should be paid, not only for admitting residents with specific needs, but also for giving high quality services as evaluated by state surveyors;
   c) Nursing home reimbursement must be linked to surveillance and enforcement, requiring facilities to spend money and/or hire staff in those areas found to be deficient.

1992

1. To improve access to nursing home care.

2. To ask AoA to direct state units to send a directive to III-B services emphasizing the right of all older Americans to receive III-B services regardless of place of residence.

3. 1992 resolution regarding bed-hold and Medicaid payment for same is continued.

1993

1. Whereas, consumers of long term care may live in any number of different settings; and
Whereas, people in any long term care setting are entitled to certain basic levels of quality of care and life;
Whereas, there are many new and divergent approaches to providing long term care being developed at a quick pace;
Whereas, there is no national information base for consumer advocates pertaining to non-nursing home settings;
THEREFORE BE IT RESOLVED THAT NCCNHR develop technical assistance and policy analysis materials on the continuum of long term care settings including assisted living, board and care, and subacute care.

2. RESOLVED THAT NCCNHR and its members advocate for a personal needs allowance of $100 per month and support the President in his proposal to increase it to $100.

1994

1. Resolved that all reimbursement systems should include incentives for the provision of high quality care and the disincentives for poor care, as well as that:
   - ш nursing facilities with reimbursement rates in excess of the state's median not be reimbursed fully for the provision of repeated substandard care;
   - ш no reimbursement systems include a profit or efficiency incentive in the direct care or resident cost areas and that all case mix reimbursement systems have programmatic requirements and quality indicators for each category of residents;
   - ш NCCNHR support efforts of member ombudsmen and advocates to impact changes in their states' reimbursement systems.

2. Resolved that NCCNHR recommend to the IoM Committee on Nurse Staffing that there be federal and state nursing home standards requiring that:
   - ш sufficient nursing staff to meet resident needs and give care in a humane, dignified manner, with accommodation of residents' routines and choices, 24 hours a day, every day;
   - ш separate minimum staffing requirements for nurses and nurse aides;
   - ш the minimum nurse aide standard be expressed as a number of nurse aides to residents;
   - ш the minimum standard for licensed nurses take into account all nursing responsibilities including direct care, assessment, care management, supervision, and administrative responsibilities;
   - ш all nursing staff have adequate training and experience to perform their duties, specific to the resident populations they serve;
   - ш minimum standards not be treated as maximums, and that actual staffing levels be sufficient to enable each resident to achieve the highest practicable quality of care and quality of life.

3. Resolved that NCCNHR seek immediate action by the Department of Health and Human Services to:
   - ш issue proposed regulations banning financial disclosure and other practices used to discriminate against nursing home applicants;
   - ш swiftly consider comments on the proposed regulations and issue final regulations banning discriminatory practices;
   - ш take interim steps to prevent discrimination, including but not limited to, notifying all certified nursing facilities of their responsibilities, educating consumers about their rights, and enforcing existing civil rights requirements;
   - ш develop and implement data collection and survey procedures to detect and evaluate practices that discriminate against Medicaid recipients and minorities.

4. Resolved that NCCNHR support and endorse "National Career Nurse Assistants' Day" the first week in June on national, state and local levels.

5. Resolved that national policy should include:
   - ш Staffing standards in nursing homes and other licensed congregate residential environments which reflect the key role played by nurse aides;
   - ш Develop standards which tie staffing minimums of staff to levels of care provided;
   - ш encouragement of full participation by caregivers and their unions in ensuring the quality of care.

1995

1. Consumers' minimum standard for nurse staffing in nursing homes. For every nursing facility:
   - ш A full time RN Director of Nursing
   - ш A full time RN Assistant Director of Nursing (in facilities of 100 beds or more)
   - ш A full time Director of In-service Education

ш An RN nursing supervisor on duty at all times (24 hours, 7 days per week)
ш Direct Care givers (RN, LPN, LVN, or CNA)
Day 1:5 residents
Eve 1:10 residents
Night 1:15 residents
ш Licensed Nurses (RN, LPN, or LVN)
Day 1:15 residents
Eve 1:25 residents
Night 1:35 residents
These standards are only minimums and must be adjusted upwards to meet the care needs of residents. These requirements must be in place for all residents, regardless of payment source. No on-going waivers of these standards should be allowed.

2. NCCNHR will authorize and assist the development of a Task Force on Nurse Assisting. This Task Force shall be convened for the purpose of identifying issues critical to nurse assisting in training, supervision, new roles and responsibilities, recognition, provision of quality care, staffing, work-life and other pertinent areas.

1996

1. NCCNHR will:

ш identify retaliation and factors that contribute to fear of retaliation against residents and those acting on their behalf as an advocacy priority

ш develop the criteria, means and resources to begin the collection of such information that will describe it more accurately and in greater detail

ш use the resulting information to foster more targeted advocacy initiatives against retaliation.

2. NCCNHR calls on the federal government to:

ш develop a standardized form for reporting nursing services hours that distinguishes direct care nursing and administrative nursing services, shows the distribution of hours served by different categories of nursing personnel (aides in training, certified nurse aides, student nurses, licensed practical nurses, registered nurses) by hour of the day and day of the week;

ш require that each certified facility post this staffing information in understandable language, in an easily accessible location for public inspection, available to residents, family, staff, prospective residents and their families and advocates;

ш require that this public information be up-dates monthly;

ш require that this staffing information, for any two week period designated by the surveyor, be reported in standardized form annually to the State and the U.S. Health Care Financing Administration.

3. NCCNHR calls on the President of the United States to direct the Department of Health and Human Services to deny any requests for waivers that fail to ensure the integrity of the inspection survey or which fail to implement enforcement without exception.

4. **NCCNHR 1997 Goals**

By the 1997 annual meeting, the Coalition, through its members and staff, will:

Support the growth of the Long-Term Care (L.T.C.) consumer movement through the following:

- With NCCNHR publications and training, empower 25,000 long term care consumers and workers to expect quality and giving them the skills to bring the standards embodied in the NHRL into their daily experience.
- Have further interaction with at least 5,000 of these consumers and workers, in the form of new memberships, repeat orders or direct requests for assistance.
- Five or more citizen groups will be established or enriched with NCCNHR's help to foster systems change that will improve the quality of life for L.T.C. residents.
- Through these interactions, the Coalition gains new insights from consumers and workers directly involved in L.T.C..

Promote consumer-centered Long-Term Care practices through:
Identification and promulgation of best practices in care through QCA and sessions at the annual meeting.
- identification of problem areas in which the development of new practice standards is needed, through QCA and sessions at the annual meeting and initial development of one additional publication.
- work in collaboration with other national groups to develop and promote standards and models for best practices through the Campaign for Quality Care.
- securing resources to enable NCCNHR to identify, develop, and promote best practice standards in emerging L.T.C. settings.
- support, protect, and promote strong state and local ombudsman programs.

Ensure consumer participation in development of public Long-Term Care policy through:
- identification of venues in which L.T.C. policy of the future is now, or should be, developed on national, regional and local levels.
- obtaining "a seat at the table" where L.T.C. policy is being, or should be, developed.
- serving as a clearinghouse which enhances the effectiveness of consumer representatives who participate in policy development.

Support consumer-centered enforcement of Long-Term Care standards. We will accomplish this by:
- highlighting at least five models of enforcement by survey agencies, U.S. Attorneys and states attorneys general who focus on residents' interests and take vigorous action to protect them;
- exposing to public media and judicial review those cases where federal and state officials substitute weakness, corrupt influence, neglect of residents' needs and off-target responses for strong resident-centered corrective actions and credible deterrents; and,
- promoting models of excellence that bring about lasting improvements through direct citizen action and private legal enforcement.

Achieve financial self-sufficiency for NCCNHR in its core mission through:
- increasing our membership
- promoting our publications and developing new materials that support our mission
- establishing a strong base of committed donors

1997

1. Let it be resolved that NCCNHR work cooperatively with the National Association of Attorneys General to urge Congress to establish, by federal legislation, a national registry for criminal background checks and screening of all personnel involved in care or treatment of the ill, elderly and incapacitated persons. These records must be available to all persons as needed for purposes of hiring.

2. Be it resolved that the National Citizens' Coalition for Nursing Home Reform will urge the President and Department of Health and Human Services to assure that regulations governing SNF prospective payment include:

- provision requiring adequate reimbursement for quality direct care nursing services with professional

nurse management and supervision,

ш provision requiring (DHHS) review and revision with public comment period of the reimbursement factors for nursing services at least annually to assure they provide for quality care,

ш provision, if case-mix is the basis for reimbursement, that requires each SNF to continually post the facility case-mix for public inspection, updating it weekly,

ш provision that requires the SNF to continually post for public inspection the nursing time used as the basis of reimbursement for each category of SNF resident,

ш provision that requires each SNF to post for public inspection the nursing services staffing for each day in the week and each tour of duty within the day, showing direct care staff for each nursing unit and supervisory staff,

ш provision that requires each SNF use all reimbursements calculated for nursing services only for nursing services.

3. NCCNHR urges Congress to enact legislation requiring that all licensed health care professionals and certified caregivers serving residents in Medicare certified Skilled Nursing Facilities and Medicaid certified Nursing Facilities receive specialized training in the care of residents with Alzheimer's disease or other cognitive impairments, as well as other mental impairments and emotional and behavioral symptoms.

1998

1. Consumer Minimum Staffing Standard for Nursing Homes (Builds on the Staffing Standards adopted by the NCCNHR membership in 1995)

Administration Standard

A full-time RN with a Bachelor's Degree would be the Director of Nursing
(A provision for grandfathering current RN Directors would be allowed for a specified time period)

A part-time RN Assistant Director of Nursing (full-time in facilities of 100 beds or more)
(This person may also be the MDS coordinator)

A part-time RN Director of In-Service Education (preferably with adult education and gerontology training)
(Full-time in facilities of 100 or more)

A full-time RN nursing facility supervisor must be on duty at all times, 24 hours per day, 7 days per week.

Direct Care Staffing Standard

The minimum number of direct care staff must be distributed as follows:

Minimum Level Direct Care Staff (RN, LVN/LPN, or CNA):

Day Shift	1 FTE for each 5 Residents	(1.60 hours per resident day)
Evening Shift	1 FTE for each 10 Residents	(0.80 hours per resident day)
Night Shift	1 FTE for each 15 Residents	(0.53 hours per resident day)

And Minimum Licensed nurses (RN and LVN/LPNs) providing direct care, treatments and medications, planning, coordination and supervision at the unit level:

Day Shift	1 FTE for each 15 Residents	(0.53 hours per resident day)
Evening Shift	1 FTE for each 20 Residents	(0.40 hours per resident day)
Night Shift	1 FTE for each 30 Residents	(0.27 hours per resident day)

The minimum total number of direct nursing care staff would be 4.13 hours per resident day.

These requirements should be in place for all residents, regardless of payment source and no waivers of these standards should be allowed. (Administrative staff would be excluded from the direct care standard except in facilities with 30 or less residents).
Nurses and nurse aides must be counted only once in determining the adequacy of staff in skilled nursing facilities and nursing facilities that operate non-nursing units and home agency services.

Staffing must be ADJUSTED UPWARD for residents with higher nursing care needs. For example, residents classified under the Resource Utilization Groups (RUGs) as being in the category requiring extensive nursing care received an average of 6.2 hours of nursing time per resident day in the 1995-1997 time studies.**

Mealtime Nursing Staff
Direct care staffing standards will take into account specific needs of residents at mealtimes. At all mealtimes, there will be:

1 nursing FTE for each 2-3 Residents who are entirely dependent on assistance.
1 nursing FTE for each 2-4 Residents who are partially dependent on assistance.

Residents must be encouraged to remain as independent as possible in feeding themselves, and this may require more staff time than would be required if residents were fed entirely by someone. Nursing staff who assist with feeding must be certified nursing assistants who are adequately trained in feeding procedures and they must be supervised by licensed nurses.

Education and Training
All licensed nurses in nursing homes must have continuing education in care of the chronically ill and disabled and/or gerontological nursing (at least 30 hours every two years).

Nursing assistants should have a minimum of 160 hours of training, including training in appropriate feeding techniques (at least 12 hours relevant training every year).

Nurse Practitioners
Each nursing home is strongly urged (but not required) to have a part-time Geriatric or Adult Nurse Practitioner and/or a Geriatric Clinical Nurse Specialist on staff (full-time for 100 beds or more).

Disclosure: Public Right to Staffing Levels
A long-term care nursing facility shall post for each wing and/or floor of the facility and for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care and the current ratios of residents to staff, which show separately the number of residents to licensed nursing staff and the number of residents to (direct caregivers) unlicensed staff. This information shall be displayed on a uniform form supplied by the licensing agency.

In addition, such information shall be posted for the most recently concluded cost reporting period in the form of average daily staffing ratios for that period. This information must be posted in a manner which is visible and accessible to all residents, their families, caregivers and potential consumers in each facility. A poster provided by the licensing agency which will describe the minimum staffing standards and ratios (listed above) shall also be posted in the same vicinity.

A list, in at least 48 point type, showing the first and last names of nursing staff on duty shall be posted at the beginning of each shift prominently on each unit.

** 1995-1997 HCFA time studies found about 8 percent of residents were in the RUGs category that requires extensive nursing care. Approximately 50 percent of the time for the extensive nursing residents in the HCFA 1995-1997 national time studies were for licensed staff and of that 57 percent was for RN time. For residents in the rehabilitation RUGs category, the nursing time spent averaged 5 hours per resident day, of which 50 percent was for licensed staff time and, of that, 50 percent was RN time.) Burke, B., and Cornelius, B. 1995 and 1997

Staff Time Measurement Study. Baltimore, MD: Health Care Financing Administration Multi-state Casemix Demonstration Project, August 1998.

1999

1. Be it resolved that NCCNHR call for the Informal Dispute Resolution process to be eliminated.

2. Be it resolved that NCCNHR urge HCFA to adopt the following changes in the Nursing Home Regulations:

- At the annual survey the surveyor must determine whether or not the facility has a Family Council as defined in the Federal Regulations
- If a Family Council as defined in the Federal Regulations does exist, the surveyor must notify and interview a Family Council representative, provide an opportunity for input into the survey, and invite that representative to be present at the exit interview
- If a Family Council as defined in the Federal Regulations does not exist, the surveyor must review and verify what action has been taken by the facility to facilitate the establishment of a Family Council
- Since the Federal Regulations require the facility to appoint a representative to listen to and act upon recommendations of the Family Council, the surveyor must examine a copy of the recommendations and documentation as to action taken upon such recommendation.

3. Be it resolved that NCCNHR implore HCFA to accomplish the following:

- Assure the OBRA regulations for special care units are strongly enforced and evaluate whether additional regulatory protections should be established for special care units
- Mandate all special care units to provide dementia-specific training to all employees
- Require nursing homes to fully disclose in admission contracts what services are provided in their special care units and add tasks to the survey process that require state and federal survey agencies to measure compliance and enact meaningful penalties
- Require staffing levels in special care units to reflect the acuity level of residents in special care units.

4. Amends 1993 resolution. NCCNHR will ask Congress to raise the personal needs allowance from $30 to $100 and automatically increase the amount yearly by the same percentage as the Social Security COLA.

5. NCCNHR shall advocate that Congress shall require one 8-ounce glass of water with each meal unless there is a physician's order not to do so. This shall not abrogate any resident's right.

6. Be it resolved that NCCNHR and its member groups work at a state and national level with residents, families, workers and other interested organizations to fight for a platform of Nursing Home Initiatives, including:

- Minimum staffing ratios (as passed by NCCNHR in 1998)
- An acuity-based staffing standard for Medicare residents that requires nursing facilities to staff levels for which they are being reimbursed
- Reforming the reimbursement system to provide funding adequate to improve staffing and reduce turnover, including:
  -- reimbursement earmarked for appropriate staffing for direct care workers and licensed nursing staff as in the NCCNHR standard
  -- implementation of policies that will assure wages and benefits more commensurate with the skill and value of direct care work
  -- implementation of policies that serve to promote a stable, high quality work force
- Increased training of nursing home staff to understand the increasingly complex needs of the residents
  Increased education and training for CNAs should include:
  -- improved initial classroom preparation

-- a formal learning period between classroom time and certification
-- on-going learning to support continuous job skills development
-- other needed training to support CNAs in providing good care

- Encourage vigorous enforcement at state and national levels of the OBRA '87 standards, especially for repeat offenders

7. With respect to Certified Nursing Assistant Career Growth Opportunities, NCCNHR should advocate for:
    - A redesign of workloads according to the individual resident needs
    - Creating a base of pay for the basics of the job
    - Creating some kind of recognition or incentive program for increased knowledge and education
    - Passage of a Bill of Rights and Standards of Practice

8. Be it resolved that NCCNHR advocate for:
    - Congress to appropriate sufficient funds to enable federal and state survey agencies to conduct all survey and enforcement activities required by federal law
    - Congress to appropriate for fiscal year 2000 at least the amount proposed in the President's budget and reject industry-proposed reductions
    - Congress and HCFA to reject all industry efforts to replace the federal survey protocol with a collaborative approach of the industry's development, through statutory change, Medicaid waivers, or otherwise
    - HCFA to direct states to develop and implement programs in collaboration with residents' advocates, beginning in fiscal year 2000, to educate consumers, including residents, families, and friends, about the federal survey process and their roles in it.

2000

1. RESOLUTION ON TORT REFORM

WHEREAS, residents of this nation's nursing homes are among its most vulnerable population;

WHEREAS, data compiled by the Health Care Financing Administration show that more than one-half of the nursing homes in the United States are staffed at or below levels that have been shown to cause actual harm, or even death to these residents; and

WHEREAS, it is vitally important that those who have undertaken the responsibility for their care be held fully accountable for the care they provide or fail to provide;

WHEREAS, state survey agencies alone cannot fully enforce nursing *home* regulations;

WHEREAS, state survey agencies' role does not include representing residents personally or securing compensation and justice for residents who are injured;

WHEREAS, among the systems in *place* designed to achieve quality of care and accountability for poor care is the justice system;

WHEREAS, attempts are being made to erode or eliminate the rights of nursing home residents to hold nursing homes accountable in courts of law, including efforts to include mandatory mediation or arbitration clauses.

NOW, THEREFORE, BE IT RESOLVED that the National Citizens' Coalition for Nursing Home Reform strongly opposes any efforts at the state or federal level to erode or eliminate the rights of nursing home residents to hold nursing homes fully accountable in the courts of law.

2. RESOLUTION REGARDING NURSING ASSISTANTS

WHEREAS, the role of nursing assistants is critical to the well-being of residents and to quality care in nursing homes, and,

WHEREAS, the quality of life for nursing assistants has a direct bearing on their ability to give good care, and,

WHEREAS, a living wage commensurate with the important responsibilities given to nursing assistants to perform is crucial to the well-being of nursing assistants and,

WHEREAS, experienced nursing assistants have unique insights and understanding of care needed for quality provision of service, and

WHEREAS, trained and supported nursing assistants provide better care to residents,

THEREFORE, BE IT RESOLVED THAT NCCNHR SUPPORT a mandated role for the nursing assistant in the care planning process; training for nursing assistants in the care planning process; living wages for nursing assistants which reflect the important work which they perform; the participation of experienced nursing assistants in the development of training curriculum or new nursing assistants.

3. RESOLUTION ON EMERGENCY RESPONSE TO CRIMES IN NURSING HOMES

WHEREAS, residents of this nation's nursing homes are among its most vulnerable population;

WHEREAS, theft, neglect and abuse are crimes that occur in nursing homes as they do in other settings;

WHEREAS, the occurrence of a crime warrants a rapid response by personnel fully trained with the skills and armed with the tools to investigate and apprehend the perpetrator and bring that individual to justice;

WHEREAS, individuals are often unaware of or are afraid of exercising their right to utilize the services of law enforcement and other emergency response personnel, including 911 calls, in a nursing home setting;

WHEREAS, many law enforcement and other emergency response personnel lack training in responding appropriately to crimes in nursing homes;

WHEREAS, responding to crimes in nursing homes may sometimes require special expertise not necessarily possessed by such personnel

NOW, THEREFORE BE IT RESOLVED THAT NCCNHR strongly supports efforts to educate residents, their families, and other concerned citizens of the importance of accessing law enforcement and other emergency response personnel when confronted with crimes in nursing homes;

BE IT FURTHER RESOLVED THAT NCCNHR strongly supports Department of Justice and other initiatives to train law enforcement and other emergency response personnel in responding to crimes in nursing homes including the formation of special interdisciplinary teams to handle such crimes.

4. RESOLUTION OF ENFORCEMENT OF REGULATIONS REGARDING RESIDENT AND FAMILY COUNCILS

WHEREAS, resident and family councils play an important role in improving quality of care;

WHEREAS, the regulations regarding family and resident councils are rarely enforced;

WHEREAS, family and resident councils are often directed by facilities;

THEREFORE, BE IT RESOLVED THAT NCCNHR SHOULD SUPPORT aggressive enforcement of regulations related to resident and family councils including: facilities supporting their development as independent and autonomous entities.

5. NCCNHR RESOLUTION CALLING ON THE PRESIDENT OF THE UNITED STATES TO REQUIRE EXPERT NURSING DESIGN AND MANAGEMENT OF THE OBRA 1990 MANDATED STUDY AND REPORT TO CONGRESS, OF APPROPRIATE MINIMUM CAREGIVER TO RESIDENT RATIO AND SUPERVISOR TO CAREGIVER RATIOS IN NURSING FACILITIES[1]

WHEREAS, The Health Care Financing Administration was given the responsibility of conducting the OBRA 1990 mandated nursing home staffing study, and has delayed it for over eight years, and while serious understaffing continued to contribute to substandard care and harmful neglect in nursing homes across the country, placing residents in immediate jeopardy; and,

WHEREAS, Phase 1 of the HCFA study[2] (reported August 1, 2000) continues to delay the mandated study by failing to address the minimal staffing requirement for good care, the caregiver roes of register nurses (RN) and Licensed Practical or Vocational Nurses (LPN/LVNs) and the supervisory roles of RNs and LPN/LVNs at the nursing unit level, as well as the supervisory and educational roles of RNs at the facility level and nursing services administration level; And, Where as, the health status of residents of nursing homes is characterized by frailty, sensory deficits, functional disabilities, chronic illness and occasional acute illness, these residents need professional nurse evaluation, planning and management of care in the institutional setting, and,

WHEREAS, nursing responsibilities include care delivery according to professional standards of care and appropriate delegation of responsibility to trained personnel, as well as conformance with state and federal reporting requirements,

THEREFORE, BE IT RESOLVED THAT NCCNHR call on the President to require that design and management of the OBRA `90 study now be guided by nurse experts who understand these responsibilities including representatives of AANAC, NADONA-LTC, NGNG, and NAGNP charging them with recommending minimum caregiver to resident and supervisor to caregiver ratios on the basis of time and skills needed for delivery of all levels of nursing services, and meeting all nursing responsibilities including: assessment of care needs, planning of individualized resident care, assignment of care responsibilities, provision of direct care, evaluation of resident response to care, unit management and coordination of care, supervisory, administrative and educational roles of professional nurses.

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[1]Budget Reconciliation Act of 1990, Congressional Record, October 26, 1990, H12487
[2]www.hcfa.gov. "What's New," August 1, 2000 Report to Congress Appropriateness of minimum Nurse Staffing Ratios in Nursing Homes.

2001 – There were no resolutions in 2001 because of the cancellation of the Annual Meeting due to the September 11 terrorist attacks in Washington and New York.

2002

A. *RESOLUTION ON ASSISTED LIVING*.

RESOLUTION

WHEREAS, many older people with healthcare needs are moving to assisted living facilities as an alternative to nursing facilities; and

WHEREAS, many residents in assisted living facilities have healthcare needs similar to needs of nursing facility residents; and

WHEREAS, two hearings held by the Senate Special Committee on Aging identified and documented significant problems in the care provided by assisted living facilities to their frail, older residents; and

WHEREAS, the General Accounting Office has identified and documented substantial inconsistencies between assisted living facilities' marketing materials and admissions contracts; and

WHEREAS, the assisted living industry increasingly seeks public reimbursement for providing assisted living services to older individuals; and

WHEREAS, the Assisted Living Workgroup has been convened at behest of the Senate Special Committee on Aging to address concerns about assisted living and to try to achieve consensus on the definition and regulation of assisted living facilities,

THEREFORE BE IT RESOLVED, that the National Citizens' Coalition for Nursing Home Reform supports strong regulation of assisted living facilities at the state and federal levels to ensure that residents receive the care and services they need and that residents' rights are fully protected, and

BE IT FURTHER RESOLVED, that state legislatures and regulatory systems recognize that many residents of assisted living facilities have healthcare needs similar to those of nursing home residents and that they provide the appropriate regulatory protections;

BE IT FURTHER RESOLVED, that federal funding for assisted living be provided only in separate individual units.

B. RESOLUTION ON MEDICAL RECORDS.

RESOLUTION

WHEREAS, medical records are essential for providing appropriate assessment, care plans and resident assistance and care; and

WHEREAS, a vital element in providing adequate care to nursing home residents is knowledge of services involving activities of daily living and other care services which are required by the plan of care or assessment, on a shift by shift basis, so as to be readily available for use in planning and rendering care to each resident on each succeeding shift on a consistent basis; and

WHEREAS, the recording of care services rendered, including care involving activities of daily living and other services required by the plan of care or assessment, is not regular and uniform in all long term care facilities, and is generally not included in the medical records of the resident so as to be readily available for use in planning and rendering care of such resident on each shift; and

WHEREAS, the actual falsification of nursing home records by licensed nursing staff and others has been documented extensively through complaints, lawsuits, and news articles;

WHEREAS, there is little regulatory specificity relative to these practices, or penalty for either engaging in, or directing another to engage in, inaccurately recording information in medical records;

THEREFORE, BE IT RESOLVED THAT, the Federal Government establish a requirement for accuracy in the maintenance of nursing home medical records (including those completed by Certified Nursing Assistants) and a specific penalty be required for anyone entering inaccurate data or inducing another to do so.

BE IT FURTHER RESOLVED, that the Federal Government establish a requirement to direct nursing homes to maintain in the medical records for each resident a daily chart of certified nursing assistant services provided to the resident, to be completed by each certified nursing assistant who is rendering care by the end of his or her shift, such record to indicate assistance with activities of daily living, assistance with eating, and assistance with drinking, and to include each offering of nutrition and hydration for those residents whose plan of care or assessment indicates a risk for malnutrition or dehydration, and any other care services which are required to be rendered under the plan of care or assessment.

C. ***RESOLUTION ON THE OMBUDSMAN PROGRAM.***

RESOLUTION

WHEREAS, the Long-Term Care Ombudsman Program was established to advocate for the rights and interests of residents in long-term care facilities and to work with communities and citizens groups to improve the well-being of residents in long- term care facilities, in part because of concerns about the government's ability to enforce laws governing the quality of care and the protection of the rights of residents; and
WHEREAS, the Older Americans Act requires that the Long-Term Care Ombudsman Program be free of conflicts of interest and free from willful interference in the performance of its duties in order to wholly represent residents; and
WHEREAS, research has shown that to be effective, Ombudsman Programs must be able to pursue independently all reasonable courses of action that are in the best interests of residents, including but not limited to legislative activity, testifying on any issue they deem important, contact with the media, meeting with government officials, supporting the formation of family councils, and all other responsibilities set forth in the Older Americans Act;" and
WHEREAS, the Administration on Aging (AOA) is responsible for approving state plans and receiving and monitoring assurances that the Long Term Care Ombudsman Program is in compliance with the Older Americans Act and other pertinent laws; and
WHEREAS, in many states, the Long-Term Care Ombudsman Program is not able to carry out all its functions and is prevented from full and effective advocacy on behalf of residents; and
WHEREAS, long-term care facility residents and their families are harmed when conflicts of interest, inadequate financial resources, and willful interference with ombudsmen in the performance of their responsibilities prevent the ombudsman program from being fully effective in resolving the complaints of residents and protecting their well-being and rights; and
WHEREAS, the Administration on Aging has failed to promulgate regulations based upon the 1992 and 2000 amendments to the Older Americans Act regarding the ombudsman program;

THEREFORE, BE IT RESOLVED THAT the Administration on Aging begin immediately to develop and implement procedures to ensure that states are held accountable for assuring the ability of ombudsmen to pursue independently all reasonable courses of action that are in the best interests of residents, including eliminating conflicts of interest and willful interference with representatives of the program, and to establish effective mechanisms to receive and resolve citizens' complaints about interference with or conflicts of interest in ombudsman programs;

BE IT FURTHER RESOLVED THAT the Administration on Aging immediately promulgate regulations for the ombudsman program that are consistent with the Older Americans Act and support the program's authority and ability to work without interference or conflict of interest.

BE IT FURTHER RESOLVED THAT Congressional committees and individual senators and representatives concerned about the quality of care in long term care facilities ensure that the executive branch carries out its duties regarding the administration of and oversight over the long-term care ombudsman program and seek further legislative remedies as appropriate.

D. ***RESOLUTION ON ADMISSIONS AGREEMENTS.***

RESOLUTION

WHEREAS, nursing home residents and their families often rely heavily upon the nursing home for information and trust that the information provided is accurate and legal; and

WHEREAS, the admission agreement is an important document that defines the business relationship between the resident, family and nursing home; and

WHEREAS, several studies have shown that such agreements often contain misleading, inaccurate or erroneous information; and

WHEREAS, some agreements require residents or family members to agree to provisions, such as arbitration clauses, that are illegal or are violations of residents' rights; and

WHEREAS, the admission process is often profoundly stressful for both the resident and the resident's family, who are not in an equal bargaining position with the facility,

THEREFORE BE IT RESOLVED that the federal government require that all facility admissions agreements be free from provisions that are invalid or likely to confuse or deceive residents or their family members, thus depriving residents of the protections afforded under state and federal law. Be it further resolved that the federal government require nursing facilities to use standardized admission agreements which have been reviewed and approved by the state survey agency.

E. ***RESOLUTON ON STAFFING.***

RESOLUTION

WHEREAS, there is a direct relationship between the quantity and quality of staff in a nursing home and the quality of care and quality of life of the residents of the facility; and

WHEREAS, a congressional report provides compelling evidence that quality care cannot be delivered with less than an average of 4.1 hours of nursing care per resident per day, which findings are consistent with other research and expert opinion; and

WHEREAS, under the Medicare reimbursement system, nursing homes receive higher reimbursement for higher level acuity residents;

Whereas in an effort to maximize profitability many nursing homes seek higher acuity residents without adding staff in proportion to the elevated needs of these residents; and

WHEREAS, nursing homes are often driven to maximize their census even if inadequate resources are available to meet the needs of the residents;

THEREFORE BE IT RESOLVED that the Centers for Medicare and Medicaid Services require states to cite nursing facilities for staffing violations when they have quality of care deficiencies that are related to failure to staff adequately and that reasonably could have been avoided by staffing at levels identified as necessary for quality care in a three-volume report to Congress, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*; and

BE IT FURTHER RESOLVED that when nursing facilities are cited for quality of care violations related to understaffing, or fall below state nurse staffing standards, they place a moratorium on new admissions until they are in compliance and remain in compliance for a minimally reasonable period of time;

F. ***RESOLUTION ON TORT REFORM.***

WHEREAS, residents of this nation's nursing homes are among its most vulnerable population;

WHEREAS, data compiled by the Centers for Medicare and Medicaid Services show that more than one-half of the nursing homes in the United States are staffed at or below levels that have been shown to cause actual harm, or even death to these residents; and

WHEREAS, it is vitally important that those who have undertaken the responsibility for their care be held fully accountable for the care they provide or fail to provide;

WHEREAS, state survey agencies alone cannot fully enforce nursing home regulations;

WHEREAS, state survey agencies' role does not include representing residents personally or securing compensation and justice for residents who are injured;

WHEREAS, among the systems in place designed to achieve quality of care and accountability for poor care is the justice system;

WHEREAS, attempts are being made to erode or eliminate the rights of nursing home residents to hold nursing homes accountable in courts of law, including efforts to include mandatory mediation or arbitration clauses in admissions agreements and to cap punitive damages and damages for pain and suffering;

NOW, THEREFORE, BE IT RESOLVED, that Congress and state governments should strongly oppose any legislation, including the HEALTH Act passed in the House of Representatives as H.R. 4600 and introduced in the Senate as S. 1370, which would erode or eliminate the rights of nursing home residents to hold nursing homes fully accountable in the courts of law.

2003

RESOLUTION: ACCURACY IN THE REGULATORY AND ENFORCEMENT SYSTEM

WHEREAS, the General Accounting Office has repeatedly reported that state survey agencies describe deficiencies as causing no harm to residents when they do cause harm (also known as “undercoding”); and

WHEREAS, the minority staff of the House Government Operations Committee has made similar findings of undercoding in more than a dozen reports; and

WHEREAS, undercoding allows inaccurate information to be reported on CMS’s website, Nursing Home Compare, giving the public a false impression that deficiencies are less serious than they actually are and that no harm is occurring to residents when harm is occurring; and

WHEREAS, undercoding causes regulatory agencies to impose less stringent remedies -- or no remedies at all -- against facilities that cause harm to residents; and

WHEREAS, undercoding leads Administrative Law Judges to misunderstand the extent and severity of deficiencies and, consequently, to reduce penalties that are imposed by regulatory agencies;

THEREFORE BE IT RESOLVED, that the Centers for Medicare & Medicaid Services undertake appropriate actions to assure that federal and state survey agencies accurately code deficiencies, such actions to include (1) clarifying instructions in the State Operations Manual on properly coding severity of deficiencies, (2) conducting training sessions for surveyors on correct coding of deficiencies, and (3) issuing a report to the Senate Finance Committee and the public on or before January 1, 2005 describing actions taken by CMS to improve the accuracy of deficiency coding.

RESOLUTION on INDEPENDENT FAMILY COUNCILS

WHEREAS, there are insufficient numbers of trained ombudsmen and surveyors to monitor care of nursing home residents, and in many instances, surveyors' annual visits are frequently predictable,

WHEREAS, many families, personal representatives, and friends of residents are in nursing homes many hours each day and should be a vital component in improving quality of care and quality of life for residents; and

WHEREAS, many family members, personal representatives and friends of nursing home residents wish to be more involved in ensuring quality care and quality of life for residents, but are hesitant to express their concerns over care issues in family councils, many of which are directed and substantially controlled by facility staff, for fear of retaliation in many forms against them or their resident loved one; and

WHEREAS, families have the right to ask for assistance from all sources, including citizen advocacy groups, state and local ombudsman programs, regulatory agencies, and public law enforcement officials; and

WHEREAS, the nursing home industry is actively organizing residents' families and friends into groups that will promote the industry's agenda of increasing public reimbursement, reducing public oversight, and promoting tort reform; and

WHEREAS, the present federal laws do not adequately establish the independence of family councils, encourage their formation, or provide adequate protection for residents and their families, personal representatives and friends against retaliation when they raise concerns over care issues;

NOW, THEREFORE, BE IT RESOLVED THAT, the Centers for Medicare & Medicaid Services promulgate regulations to strengthen the ability of family councils to improve the quality of care and quality of life in nursing homes.

BE IT FURTHER RESOLVED THAT, such regulations should require facilities to assist in the development of family councils that operate independently of facilities, such assistance to include (1) assigning a specific staff person to provide prompt assistance to the family council upon its request and to respond promptly, acting on behalf of the facility, to written requests or concerns that result from family council discussions, meetings, or activities; (2) providing adequate private space for meetings; (3) providing adequate space on a prominent and easily visible bulletin board in a public area of the facility for meeting notices, minutes, newsletters, or other pertinent information from the family council; (4) including notice of family council activities, including time, place, and date of meetings, in any regularly-scheduled mailings sent by the facility to family members; and (5) providing information about the family council to new residents, family members, and personal representatives during the admissions process, including the name, address, and phone number of family council representatives to contact for further information; and

BE IT FURTHER RESOLVED THAT, such regulations should prohibit facilities from interfering with or retaliating in any way against residents or members of independent family councils because of the development of an independent family council or any protected activities of family councils;

BE IT FURTHER RESOLVED, that the Centers for Medicare & Medicaid Services issue guidance in the State Operations Manual directing surveyors to determine facilities' compliance with requirements governing family councils in each survey and to meet with each family council at least during the annual survey, and directing survey agencies to impose stringent remedies for violations of regulations governing family councils without giving facilities a prior opportunity to correct, and that the guidance direct states to establish a complaint process for hearing the grievances of family councils, or individuals who wish to establish or participate in family councils, when the facility fails to comply with the regulations;

AND BE IT FURTHER RESOLVED, in the event the CMS does not promulgate the aforementioned regulations in final form by January 1, 2005, that Congress enact legislation to incorporate these points and that such legislation strengthen the ability of family councils to improve the quality of care and quality of life in nursing

homes.

Resolution on DISTINCT PART CERTIFICATION

WHEREAS, the Centers for Medicare & Medicaid Services recently adopted a regulation which strengthens and gives the force of law to the requirement for Medicare and Medicaid "distinct parts" in nursing homes; and

WHEREAS, this requirement, as recently demonstrated in Indiana, causes all Medicaid residents in partially certified facilities to be segregated into a "Medicaid section" of the facility; and requires forced transfers whenever a private pay resident goes onto Medicaid; and

WHEREAS, this requirement violates the privacy, dignity, and confidentiality of Medicaid residents by relocating them into a readily identifiable "welfare" section, and damages residents through transfer trauma; and

WHEREAS, this requirement presents a severe threat of undermining the quality of care for Medicaid residents; and

WHEREAS, while this requirement does not affect residents in states which mandate full certification of facilities participating in Medicaid, it does affect residents in all states which allow partial certification; and

WHEREAS, CMS has offered no compelling reason for requiring segregation of Medicaid residents based on their source of payment and such segregation violates federal and state law:

THEREFORE BE IT RESOLVED, That the Centers for Medicare & Medicaid Services withdraw this regulation and policy on distinct part certification;

THEREFORE BE IT FURTHER RESOLVED, That, if CMS does not act by January 1, 2005 to withdraw this regulation, that Congress enact legislation to negate this regulation on the basis that it is contrary to residents' rights to privacy, dignity, confidentiality, quality care, and transfer/discharge protections.

RESOLUTION ON NURSE STAFFING INFORMATION

WHEREAS, nurse staffing data collected by the federal government's OSCAR system and reported to consumers on Nursing Home Compare has been shown to be inaccurate; and

WHEREAS, the Centers for Medicare and Medicaid Services maintains that it cannot develop a quality measure for staffing because it does not have accurate facility data on nurse staffing; and

WHEREAS, nurse staffing is one of the single most important measures of nursing home quality; and

WHEREAS, the Centers for Medicare and Medicaid Services has completed a study of how to collect accurate staffing information based on payroll and agency contract data,

THEREFORE BE IT RESOLVED THAT, The Centers for Medicare and Medicaid Services complete by January 1, 2005 a new nurse staffing data collection system that will provide accurate information about the number of registered nurses, licensed practical nurses, and certified nursing assistants in each nursing home on every shift and unit; the average ratio and range of variance of nurses and nursing assistants to residents who are available to provide direct care on each shift and unit; and the average licensed nurse and certified nursing assistant turnover rate for each facility.

BE IT FURTHER RESOLVED THAT, The Centers for Medicare and Medicaid Services post and update quarterly this data for every facility on Nursing Home Compare, and that it develop a quality measure based on this data that it posts for each facility on Nursing Home Compare.

AND BE IT FURTHER RESOLVED THAT, If CMS does not develop this data collection and reporting system by January 1, 2005, that the Congress enact legislation to ensure that CMS implements such a system.

RESOLUTION: RESIDENT PROPERTY

WHEREAS, nursing homes must help to "attain or maintain the highest practicable physical, mental and psychosocial well being" of each resident, and

WHEREAS, each nursing home resident has the right to keep and use personal possessions, and

WHEREAS, a nursing home resident's personal possessions may include dentures, eyeglasses and hearing aids, and

WHEREAS, payment or replacement for these items may not be a covered expense under Medicare or Medicaid,

THEREFORE BE IT RESOLVED THAT, The Centers for Medicare & Medicaid Services promulgate final regulations by January 1, 2005 requiring facilities to develop; implement; communicate to residents, legal representatives, and families; and post in a conspicuous place, policies and practices which require the facility to replace lost and stolen items.

RESOLUTION: AUTOMATIC SPRINKLER SYSTEMS IN NURSING HOMES

WHEREAS, more than 50 residents and workers have been killed or injured in nursing home fires in 2003; and

WHEREAS, all of these deaths occurred in older nursing facilities that were said to meet state fire safety and federal Life Safety Code requirements related to automatic fire suppression systems; and

WHEREAS, all the deaths and injuries in nursing homes in 2003 occurred after the Centers for Medicare & Medicaid Services adopted new Life Safety Code regulations that do not require older buildings to install sprinklers in resident living areas unless they undergo substantial renovations; and

WHEREAS, Medicare and Medicaid law require nursing facilities to comply with the Life Safety Code of the National Fire Protection Association; and

WHEREAS, the National Fire Protection Association and the Centers for Medicare & Medicaid Services say that automatic sprinklers are the most important life safety system in health care facilities;

THEREFORE BE IT RESOLVED THAT, Congress enact legislation to ensure the safety of nursing home residents by requiring that automatic sprinklers be installed in all facilities by January 1, 2005; and

BE IT FURTHER RESOLVED THAT, Pending implementation of the requirement for automatic sprinklers in all facilities, Congress enact legislation to require facilities to take specific steps to ensure the safety of residents, including employment of sufficient numbers of staff with adequate training in fire safety; and

BE IT FURTHER RESOLVED THAT, Congress require facilities to inform the public of their method of complying with fire safety requirements by informing individuals and their families before admission of their fire safety methods and by posting in a prominent place their fire safety methods.

RESOLUTION: STAFFING ACCOUNTABILITY

WHEREAS, a government study shows that more than 90 percent of nursing homes do not have an adequate

number of licensed nurses and certified nursing assistants; and

WHEREAS, this government study and other research compellingly demonstrate the ratio of direct caregivers to residents necessary to provide quality care; and

WHEREAS, without an adequate ratio of direct caregivers to residents, residents will suffer from pressure sores, unintended weight loss, avoidable hospitalizations, dehydration, infections, and other life-threatening and even fatal medical problems; and

WHEREAS, the level of staffing in nursing homes has not increased and has even declined when reimbursement increased because nursing homes are not held accountable for spending adequate sums on resident care; and

WHEREAS, the Centers for Medicare & Medicaid Services does not require state survey agencies to use the Investigative Protocol entitled *Nursing Services, Sufficient Staffing* in every standard survey;

BE IT THEREFORE RESOLVED THAT, Congress enact legislation to ensure that nursing homes use their public reimbursement and spend sums necessary to assure that each resident receive care and services to attain and maintain his or her highest practicable physical, mental, and psychosocial well-being and the highest quality of life possible;

AND BE IT FURTHER RESOLVED THAT, The Centers for Medicare & Medicaid Services use its existing statutory authority to require surveyors in each standard survey to identify deficiencies that are related to understaffing and to ensure that these deficiencies result in appropriate enforcement and a plan of correction that includes increasing nurse staffing to an adequate level.

2004

1. Resolution on Consumer Participation In Informal Dispute Resolution (IDR)

WHEREAS nursing homes that receive Medicare and Medicaid funding are surveyed by the State survey agency at least every 15 months to determine compliance with federal regulations, and

WHEREAS federal regulations provide for an Informal Dispute Resolution (IDR) process so that nursing homes may dispute any deficiencies found during their annual survey, and

WHEREAS this IDR process can result in deficiencies being removed or downgraded, and

WHEREAS the nursing home industry is allowed to have representatives present at the IDR hearings, including their employees, attorneys and representatives of their professional associations, and

WHEREAS nursing home residents, their family members and friends, ombudsmen and advocates are often first-hand observers of conditions in nursing homes that are the subject of deficiencies, and

WHEREAS residents, family members and friends, ombudsmen and advocates are not currently permitted to participate in IDR hearings, AND

WHEREAS currently there is no comparable process for residents, families or advocates to dispute survey findings,

THEREFORE BE IT RESOLVED THAT the Centers for Medicare and Medicaid Services amend its regulations to specify that residents, resident councils, family members and friends, family councils, ombudsmen and advocates have the right and opportunity to participate actively in IDR proceedings.

BE IT FURTHER RESOLVED that CMS should establish a separate and distinct IDR process that can be initiated by residents, family members and friends, ombudsmen, advocates, resident councils or family councils

to submit additional evidence and dispute survey findings or the absence of cited deficiencies, including complaint surveys.

2. Resolution on Release of the CMS Report on Independent Informal Dispute Resolution

WHEREAS questions arose about the objectivity of the Informal Dispute Resolution (IDR) process to air disagreements with survey findings, and

WHEREAS the U.S. House and Senate Appropriations Committees in 1999 urged the Health Care Financing Administration (HCFA; now Centers for Medicare and Medicaid Services (CMS)) to conduct pilot studies in several states utilizing an independent body to conduct IDRs, and

WHEREAS HCFA contracted with Kathpal Technologies, Inc. to conduct a demonstration project to evaluate the effectiveness of an independent Informal Dispute Resolution process, and

WHEREAS the project also included a study of current IDR approaches among the States, and

WHEREAS an expert panel was established to review and comment on the design of the demonstration project and to advise on issues concerning IDR and assist in assessing information resulting from the evaluation of the current IDR process and Independent IDR process, and

WHEREAS the pilot project was conducted in two states and the results of the project, including recommendations, were included in a final report which was delivered to the CMS in July 2003, and

WHEREAS the final report has not yet been released by CMS,

THEREFORE BE IT RESOLVED that CMS immediately release the report and allow public comment on the recommendations contained in the report.

3. Resolution on Requiring the Principles and Values Of Deep Culture Change in All Long Term Care Settings

WHEREAS, the passage of OBRA in 1987 brought standards and regulations to ensure nursing facility residents the right to “care and services to attain or maintain the highest practicable physical, mental and psychosocial well being;”

WHEREAS, across the nation singular efforts have been undertaken during recent years by several groups to promote deep culture change in different ways, including the Eden Alternative, Regenerative Community, Resident Directed Care, Individualized Care, and the Pioneer Movement, but deep culture change has not achieved widespread usage in long term care settings;

WHEREAS, deep culture change encompasses practices which nurture the human spirit as well as meeting medical needs, which follow the residents' routines rather than those imposed by the facility, which encourage appropriate assignments of staff with a team focus to make deep culture change possible, which allow residents to make their own decisions, which allow spontaneous activity opportunities, and which encourage and allow residents to be treated as individuals; and

WHEREAS, deep culture change is an important component of the right of residents to “care and services to attain or maintain the highest practicable physical, mental and psychosocial well being;”

NOW, THEREFORE, BE IT RESOLVED THAT Congress, the Centers for Medicare & Medicaid Services, Administration on Aging, and other federal departments and agencies incorporate deep culture change as an important component of quality of care and quality of life for individuals in all long term care settings, with appropriate laws, regulations, initiatives and policies.

4. Resolution on CMS Including on Nursing Home Compare Information on the Availability of Sprinkler Systems and Smoke Detectors in Each Facility

WHEREAS, a recent government study documents that there are approximately 2,300 structural fires a year in U.S. nursing homes*;*

WHEREAS, the report finds that an average of five residents a year die in fires;

WHEREAS, in 2003**,** deadly fires in Connecticut and Tennessee killed or injured more than 50 residents and workers;

WHEREAS, all of these deaths occurred in older facilities that were said to meet state fire safety and federal Life Safety Code requirements related to automatic fire suppression systems;

WHEREAS, all of the deaths in 2003 occurred after the Centers for Medicare and Medicaid Services (CMS) adopted new Life Safety Code requirements that do not require the installation of sprinkler systems in older facilities unless the facility is undergoing substantial renovations;

WHEREAS, the government study reports that 20 to 30 percent of all nursing facilities do not have sprinkler systems;

WHEREAS, even in buildings without sprinkler systems, federal fire safety standards do not require the installation of smoke detectors in residents' rooms;

WHEREAS, most residents and consumers in facilities without sprinkler systems or adequate smoke detectors are completely unaware of the facility's failure to install adequate fire safety protection;

WHEREAS, many consumers would consider the availability of sprinkler systems and smoke detectors important information in selecting a nursing facility;

THEREFORE BE IT RESOLVED that CMS include on the Nursing Home Compare website information about the existence of automatic sprinklers and smoke detectors throughout the facility, including in resident rooms and in resident and non-resident areas.

5. Resolution on Retaliation Protection for All Individuals Who Complain on Behalf of Residents

WHEREAS complaints, grievances and recommendations for changes in policy or services often are made to nursing homes by physicians, healthcare providers, friends and other individuals who provide services and support to and for residents, but they are not the residents' legal guardians, agents or representatives; and

WHEREAS federal statutes, regulations and many state laws and regulations protect residents and their legal representatives from retaliation by nursing homes as the result of making complaints and recommendations for changes made directly by residents or persons with legal standing to speak and act for residents; and

WHEREAS physicians, professional service providers, friends and other individuals who complain and recommend changes to improve residents' medical conditions and well-being but are not the legal representative of a resident have no federal or state legal protections from reprisal actions by nursing homes, except in the State of Maryland; and

WHEREAS healthcare professionals and others who provide essential medical and other services and support

for residents can better assist residents and promote their health and welfare if they have legal protections against reprisal actions by nursing homes; and

WHEREAS nursing homes have summarily denied access to care facilities by the physician or other health care provider whom the resident-patient has chosen to be her or his health care provider, or have denied access to the resident by a family member, friend, or other individual.; and

WHEREAS these arbitrary exclusions of other individuals providing medical services and general support can result in severe prejudice to the health and well-being of the resident, including grave illness and premature, unnecessary death of the resident.

THEREFORE BE IT RESOLVED THAT the Centers for Medicare and Medicaid Services (CMS) amend its grievance and protective anti-retaliation regulations in 42 C.F.R. 483.10 to prohibit arbitrary retaliation by nursing homes against physicians, healthcare providers and "other individuals" who make or file a grievance, complaint or recommendation with a nursing home for, or on behalf of a resident, even if the healthcare providers or other individuals who made the complaints do not have legal status as the resident's guardian, agent or representative; and

BE IT FURTHER RESOLVED THAT every state provide a statutory right of action for a resident or "other individual" for retaliation by a nursing home for complaints made to the care home, if the complaint is not administratively processed and resolved satisfactorily.

6. Resolution on Mechanism for Determining Direct Care Staffing Levels

WHEREAS, direct care staffing levels have been demonstrated to correlate with the quality of care provided by skilled nursing facilities; and

WHEREAS, skilled nursing facilities easily can determine direct care staffing levels; but

WHEREAS, there is no standard mechanism for determining the actual number of hours per resident per day provided to skilled nursing facility residents in the United States,

THEREFORE BE IT RESOLVED that the Centers for Medicare and Medicaid Services (CMS) direct states to implement a payroll and daily physical census-based mechanism for determining actual staffing levels in skilled nursing facilities. This mechanism shall require skilled nursing facilities to submit to designated state licensing agencies:

1. Payroll data. This payroll data shall be transmitted electronically to designated agencies, within 30 days of the last day of a pay period, under penalty of perjury, and shall indicate, for each pay period, the actual number of direct care hours paid to skilled nursing facility staff (including temporary agency staff), to the tenth hour, by type of direct care staff (e.g., C.N.A., R.N.A., LVN, RN, etc.).
2. Daily physical census data that reflects midnight physical census, exclusive of Medicaid bed hold days. This data shall be transmitted electronically to designated agencies, within 30 days of the last day of a pay period, under penalty of perjury, and shall indicate, for each day of a pay period, the actual number of residents residing in the facility as of 11:59 p.m.

This data shall provide a standard mechanism for accurately determining staffing levels in U.S. skilled nursing facilities. Aggregate direct care hours—derived from payroll data submitted for federal tax purposes—divided by aggregate resident days—derived from daily physical census counts—equals total hours of direct care per resident per day. This actual direct care staffing data shall be made readily available to the general public via the CMS Nursing Home Compare website, and shall form the basis for corrective action.

7. Resolution on Changing the Survey Process

WHEREAS, during the last approximately 2 years serious problems in the long term care survey and certification

process have been identified by the HHS Office of Inspector General in a report dated March 2003, by the Government Accountability Office, and by Senator Charles E. Grassley, a senior legislator who has historically strongly focused on protecting the rights and needs of long term care residents, and

WHEREAS, the serious problems identified include the existence of strong political or other pressures from sources other than residents; insufficient numbers of trained ombudsmen and surveyors to monitor care; cyclical compliance of facilities resulting from predictable timing of annual visits; deletion of deficiencies or downgrading of scope and severity of deficiencies; lack of thorough investigation of complaints; lack of independence of family councils; lack of adequate protection of residents and their families, personal representatives, friends of residents, and other advocates, against retaliation when they raise concerns over care issues, lack of right and opportunity for such persons to appeal determinations of "no findings" or initiate an informal dispute process themselves on behalf of residents, and

WHEREAS, it appears that the process as it now exists is not adequate to insure the right of residents to quality of care and quality of life and needs to be corrected and improved;

NOW, THEREFORE, BE IT RESOLVED THAT the Centers for Medicare & Medicaid Services correct the problems identified in the reports of the HHS Office of the Inspector General, the GAO, and Senator Charles E. Grassley, along with such other problems as may be identified in the process.

2005

1. To Prohibit Binding Arbitration Agreements

WHEREAS residents of nursing homes, assisted living facilities, and other similar long-term care residential settings and their families have a constitutional right to a trial by jury, but many facilities are now including binding arbitration agreements in their admission agreements and other documents that require abused or neglected residents to arbitrate their claims rather than exercise their right to a trial by jury and;

WHEREAS such long-term care facilities prefer arbitrations because most arbitration awards impose less accountability than what would be expected from a jury of our peers and;

WHEREAS many long-term care residents and their families are under extreme stress during the admission process and sign arbitration agreements, without understanding or an awareness of them, without an opportunity to negotiate the terms of the agreements, and without having them reviewed by an attorney prior to signing them;

NOW THEREFORE LET IT BE RESOLVED THAT federal, state and local governments prohibit binding arbitration agreements in long-term care facility admission contracts and other documents; and

BE IT FURTHER RESOLVED THAT the Centers for Medicare and Medicaid Services (CMS) issue regulations to prohibit long-term care facilities from including binding arbitration language in their admission agreements or any other documents.

2. To Require Ownership Information on Nursing Home Compare

WHEREAS information on nursing home ownership is often sought by family members, consumer advocates, unions, and state long-term care ombudsmen, but currently there is no easy way for consumers to identify a nursing home's owners and there is no single publicly accessible repository of information on nursing home ownership; and

WHEREAS a nursing home's building and license may be held by two different entities, and the day-to-day administration may be conducted by a management company; and

WHEREAS nursing home companies have begun dissolving their "chains" and are putting each facility into separate Limited Liability Corporations to avoid accountability, making it even more difficult for consumers to obtain ownership information; and

WHEREAS the Securities and Exchange Commission does not require all corporations to file reports, and there are different state laws governing nursing home corporations,

NOW THEREFORE LET IT BE RESOLVED that CMS develop a system to gather comprehensive nursing home ownership information and post that information on the CMS Nursing Home Compare website.

BE IT FURTHER RESOLVED that the website, for each nursing home listed, post information on: changes in the ownership of licenses, buildings, land, and management companies, including all former names, owners, and their effective dates; the existence of a receiver or other temporary management arrangement, and the identification of the governing body.

3. To Safeguard Residents When Nursing Home Ownership Is Transferred

WHEREAS the overall structure of the nursing home industry is changing from business enterprises primarily geared to care of infirm residents to business enterprises increasingly dominated by for-profit nursing home chains or other types of ownership that are governed primarily by the need to show profits and satisfy stockholders or investors, and

WHEREAS this change in structure tends to make facilities subject to frequent buying and selling, primarily to optimize profits, while disregarding the need to safeguard resident care, which appears to be the situation in a presently pending sale of the second largest nursing home chain in America, with approximately 37,000 residents, to a company which previously bought another major chain and immediately sold its real assets and reduced its net worth from more than $1 billion to less than $12 million, and whereas vendors are now filing legal actions based on claims of nonpayment for goods and services, thereby calling into question the quality of resident care in the impacted facilities; and

WHEREAS efforts are also being made by some companies not generally engaged in the ownership, operation and management of nursing homes to participate in such ownership, operation and management, through unique business arrangements generally known as “hostile takeovers;” and

WHEREAS the ownership, operation and management of nursing homes requires unique and particular ownership, operation and management capabilities in order to adequately safeguard the health, welfare, and well-being of residents, who must not be endangered or disregarded in such transfers of ownership; and

WHEREAS state regulatory agencies may presently have neither the authority nor ability to track financial stability of companies that acquire groups or chains of nursing homes, and may be unable to ensure the care of residents who would be affected if a group or chain which owned many nursing facilities would declare bankruptcy and close its doors, or if nursing homes were acquired by investors who did not have the necessary ownership, operation and management capability;

NOW THEREFORE BE IT RESOLVED that Congress, the Centers for Medicare and Medicaid Services, the Department of Justice, and/or other appropriate federal or state agencies be called upon to require a written plan for provision of adequate and appropriate care for residents of groups or chains of nursing homes affected by any proposed sale or other type of transfer of ownership, such plan to be approved by an appropriate federal agency before any such transfer of ownership may proceed or be concluded, and further to prevent and prohibit hostile takeovers from being used in the acquisition of groups or chains of nursing homes, by any practical means including preventing of the issuance of certification and licenses to transferees.

4. To Strengthen Resident Councils

WHEREAS the passage of the 1987 Nursing Home Reform Law brought important standards and regulations to “care and services to attain or maintain the highest practicable physical, mental and psychosocial well being;” and

WHEREAS the 1987 Nursing Home Reform Law, following the recommendations of the Institute of Medicine, included for the first time in federal law “the right of residents to organize and participate in groups in the facility;” and

WHEREAS the need to provide residents with the opportunity to make and execute meaningful decisions is critical to their emotional, psychological and ultimately their physical well-being; and

WHEREAS the primary purpose of a resident council is to create opportunities for residents to execute meaningful decisions; and

WHEREAS it is essential for residents to define and control all aspects of a resident council, which can evolve into any number of forms and adopt any combination of functions if they are desired by residents; and

WHEREAS a resident council can enhance a facility by offering residents and staff the benefits of group problem-solving, enhance facility-resident-staff communications, and raise self-esteem through opportunities for decision-making; and

WHEREAS a successfully implemented resident council far outweighs any administrative costs, which can be seen as an investment that provides both short-term gains and long-term dividends in the well-being of residents;

NOW THEREFORE BE IT RESOLVED THAT Congress, the Centers for Medicare and Medicaid Services, Administration on Aging and other federal and state departments and agencies foster and provide incentives for incorporating the philosophy that effective resident councils are an important component of quality of care and quality of life for individuals in all applicable long-term care settings with appropriate laws, regulations, initiatives and policies; and

BE IT FURTHER RESOLVED THAT CMS promulgate and enforce regulations that strengthen the ability of independent resident councils to improve the quality of care and life; to provide residents the opportunity to make and execute meaningful decisions in all aspects of their lives and provide for timely, comprehensive responses from facility staff to issues raised by individual residents and independent resident councils **without fear of retaliation**.

5. To Safeguard Residents in Natural Disasters and Other Catastrophic Events

WHEREAS the deaths and suffering which have occurred to residents of nursing homes, assisted living facilities and other similar long-term care residential settings during the 2005 hurricane season in America have made it clear that there are great inadequacies in the existing disaster preparedness plans for protecting the health, welfare, safety and well-being of long-term care residents; and

WHEREAS effective disaster preparedness is necessary not only for the threat of hurricanes, but also disasters related to terrorism, earthquakes, tornadoes, and other catastrophic events; and

WHEREAS it is vital to the safety and well-being of long-term care residents throughout the country that effective and appropriate disaster preparedness plans be implemented and tested to determine effectiveness,

NOW THEREFORE BE IT RESOLVED that CMS, FEMA, or other appropriate federal, state and local agencies charged with disaster preparedness immediately enact such rules or regulations as might be appropriate or necessary to effectively safeguard the health, welfare, safety and well-being of long-term care residents as a priority population throughout the country, and include in such rules and regulations that any such plans must be approved by appropriate disaster management authorities, and include requirements for periodic testing or drills on all such plans and on any generators or other equipment, transportation, fuel accessibility, driver or other personnel accessibility, or other aspects of the approved plan.

6. To Support Systems Advocacy in the Long-Term Care Ombudsman Program

WHEREAS the Long-Term Care Ombudsman Program (the “Program”) is a critical component to insuring the rights of residents in long term care facilities (the “residents”) to their highest practicable physical, mental and psychosocial well being while insuring their right to dignity, choice and self-determination (“quality of care and quality of life”) and is not only required to advocate for those rights through identification and resolution of individual complaints but also to address the broader or underlying causes of the complaints through systems advocacy; and is required to be free of conflicts of interest and willful interference in the performance of its duties; and

WHEREAS Administration on Aging commissioned the Institute of Medicine (IOM), to review the important aspects of the Program, specifically including the ability of the Program to deal with problems that affect the right of residents to their best practicable quality of care and the quality of life; and

WHEREAS this year marks the 10th anniversary of the publication of the IOM report, *Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act*, but there still continue to be many facilities throughout the country which have G or GG deficiencies and which have not moved toward more individualized resident-centered and resident-directed care which would insure residents' rights to attain and maintain their highest practicable quality of care and quality of life; and

WHEREAS the systems advocacy which exists in the Program at the present time appears to be insufficient to insure to residents their rights to the highest practicable quality of care and quality of life, and it seems necessary to focus, in a clearer and strong way, on increasing and otherwise improving the use of systems advocacy in the Program to achieve that goal, and thereby reduce harm to residents, and also to insure that the Program is in compliance with the Older Americans Act;

NOW, THEREFORE, BE IT RESOLVED that the Administration on Aging be called upon to establish effective mechanisms, through regulation, enforcement, training, or other means, to enable the Program to provide good, sufficient and adequate systems advocacy to address and correct underlying systemic problems in facilities, in addition to identification and resolution of complaints, and assuring the ability of ombudsmen to pursue independently and without interference all reasonable courses of action in the residents' interests.

2006

1. Resolution to Require States to Use Civil Monetary Penalties (CMPs) to Improve Quality of Life and Care for Residents

WHEREAS federal civil money penalties (CMPs) are a type of financial penalty established by the Nursing Home Reform Law in 1987 and implemented in final regulations that became effective in 1995 to encourage nursing homes to comply with federal requirements and to prevent poor quality of care; and

WHEREAS CMPs represent an increasingly large and valuable funding resource for fiscally constrained states to improve the quality of nursing home life and care; and

WHEREAS federal law specifies that CMPs may be used for: maintaining operations of a facility pending correction of deficiencies or closure, assisting in receiverships or resident relocation, reimbursing residents for personal funds lost or funding projects that benefit residents; and

WHEREAS CMP funds can and have been used to support projects that improve resident care and quality of life in new and/or innovative ways.

NOW, THEREFORE, BE IT RESOLVED THAT states ensure that their citizens receive the maximum potential benefit of federal CMPs by enabling their imposition (if they have not already done so) against nursing homes that fail to comply with federal standards for quality of care and by dedicating as much funding as possible for projects and programs undertaken to improve resident care and quality of life in innovative ways; and

BE IT FURTHER RESOLVED THAT states involve a wide range of stakeholders, including residents and family members, ombudsmen, family council members, members of citizen advocacy groups, providers, and individuals with grant-making experience, in setting criteria and guidelines for the use of funds and advising on proposals for use of the funds; and

BE IT FURTHER RESOLVED THAT states establish a public process including public notice of fund availability with a clear annual timeline for applications for funding of innovative projects and an objective review process, ensuring that the state survey and certification agency responsible for levying the CMPs/fines retains control over how those funds are used and is accountable for how they are used; and

BE IT FURTHER RESOLVED THAT states allocate sufficient funds for projects/activities /programs so that they can make a substantial, lasting impact and potentially a widespread impact and allocate funds for programs/projects that are practical and can be sustained and/or replicated by others after the funding has ended; and

BE IT FURTHER RESOLVED THAT states should authorize funds for innovative projects that go beyond regulatory requirements and ordinary budget items to improve residents' quality of care and quality of life, encourage person directed care, promote consumer advocacy and involvement and stimulate and support the spread of "culture change"; and

BE IT FURTHER RESOLVED THAT states should target consumer focused projects (such as work with family councils, resident councils, consumer advocacy organizations and ombudsman programs) and establish an evaluation process for all projects, using outside evaluation experts if possible; and

BE IT FURTHER RESOLVED THAT states encourage programs/projects to be jointly developed with academic organizations, consumers (or their representatives) and established experts.

2. Resolution to Exempt All Low-Income Long-Term Care Beneficiaries Covered Under Medicaid from Medicare Part D Co-payments

WHEREAS, many dually eligible residents (residents receiving both Medicare and Medicaid) living in assisted living residences, adult homes, board and care homes, and other such congregate living settings, including the elderly and those who have a physical and/or mental disability, and people receiving home and community-based services under Medicaid state plan amendments (as authorized by the Deficit Reduction Act) are low-income; and

WHEREAS, many of these residents take many prescription medications; and

WHEREAS, as low income residents, eligible for SSI and Medicaid, they cannot afford the co-payments they are required to pay under the Medicare Part D Program for these prescription medications; and

WHEREAS, the Medicaid Program, recognizing that these same residents cannot afford co-payments for medications, gives Medicaid residents the right to refuse to pay co-payments for medications, and if they refuse, still be able to receive their medications; and

WHEREAS, the Medicare Part D Program recognizes that low-income residents of nursing homes cannot afford co-payments for medications and therefore do not require these residents to pay Medicare Part D co-payments; and

WHEREAS, dually eligible assisted living residents, like dually eligible nursing home residents, receive a monthly Personal Needs Allowance because they exhaust all their income for the cost of their care and services, and are paying their required Medicare Part D co-payments out of their monthly Personal Needs Allowance; and

WHEREAS, the Personal Needs Allowance was established to pay for low-income residents' own personal, necessary and incidental expenses, and not to be used to pay for health care, health services, and other health-related expenses; and

WHEREAS, low-income assisted living residents, like low-income nursing home residents, are subject to similar individual and institutional constraints and barriers that limit their free choice; so therefore

BE IT RESOLVED, that the Centers for Medicare & Medicaid Services amend the definition of institutionalized individual (42 C.F.R. §423.772) to include a dually-eligible individual who lives in an assisted living residence, adult home, board and care home, and other such congregate living setting, including the elderly and those who have a physical and/or mental disability, and people receiving home and community-based services under Medicaid state plan amendments (as authorized by the Deficit Reduction Act); and

BE IT RESOLVED, that Congress amend Medicare Part D to exempt low-income residents living in assisted living residences, adult homes, board and care homes, and other such congregate living settings, including the elderly and those who have a physical and/or mental disability, and people receiving home and community-based services under Medicaid state plan amendments (as authorized by the Deficit Reduction Act) from being required to make co-payments for prescription drugs.

3. Resolution to Require a Federal Study of the Consequences Of Corporations Limiting Their Liability for Poor Care

WHEREAS the practice among some nursing home and assisted living corporations is to create new corporate structures to limit legal liability and accountability for poor resident care (for example, by splitting into separate limited liability companies, by making each facility a separate legal entity, by separating out real estate holdings from management and from nursing and therapeutic services, and by creating separate companies for each aspect of service), and

WHEREAS the effect of these corporate changes on the quality of care of residents appears to be largely unstudied,

THEREFORE BE IT RESOLVED that Congress and the Department of Health and Human Services or other appropriate federal agency commission a study by the Government Accountability Office or the Institute of Medicine of this practice and its consequences so that proper policies, oversight, and measures of accountability can be put into place to ensure quality care and protection of taxpayer dollars.

2007

1. To Promote the Quality of Long-Term Care by Providing Healthcare Coverage to Direct-Care Workers

WHEREAS we believe that everyone deserves to live with dignity, with as much independence as possible,

WHEREAS we know that to ensure healthcare choices for ourselves and for our loved ones in the future, we need to begin ensuring health care coverage for our caregivers today,

WHEREAS we know that two in five home care workers and one in four nursing home workers lack health care coverage,

WHEREAS emerging research has found a strong, positive link between health insurance benefits for direct-care workers and worker retention,

WHEREAS staff turnover costs taxpayers millions annually as well as affecting quality of care;

THEREFORE, BE IT RESOLVED THAT the federal government and each state government should assess the healthcare coverage needs of the direct-care workforce and work toward creating policies and programs that provide all direct-care workers with access to quality, affordable healthcare coverage.

2. To Ensure the Quality of the Direct-Care Job by Assuring Adequate Compensation for Workers

WHEREAS we recognize the essential role of the direct-care workforce in our nation's long-term care system,

WHEREAS NCCNHR's seminal 1985 study of quality highlighted the importance of caring, competent staff to a resident-centered definition of quality,

WHEREAS long-term care providers in all care settings are plagued with job vacancies, high staff and leadership turnover rates, and staffing shortages that have a grave negative impact on consumers' quality of life and care;

WHEREAS, we acknowledge that quality care is only possible when direct-care workers are valued and receive adequate compensation; training; career advancement opportunities; linkages to community services and public benefits; and are included in care-planning, decision-making; on-going quality improvement efforts; and public policy discussions.

THEREFORE, BE IT RESOLVED THAT the federal government and each state government should assess the

compensation levels received by direct-care workers from all long-term care employers to determine if those compensation levels deliver family-sustaining wages and secure health care coverage for all direct-care workers; and if the assessment determines that compensation and health care coverage are not adequate, take action to achieve these goals.

BE IT FURTHER RESOLVED THAT the federal government and each state government should assess its training requirements for all direct-care workers working in all care settings to determine if required or offered training adequately prepares direct-care workers to perform all needed and appropriate services; whether ongoing training requirements or opportunities build needed new skills; and how training opportunities can be improved.

3. To Ensure the Protection of Medical Records in Closed Long-Term Care Facilities

WHEREAS, all long-term care facilities are required by federal law (HIPAA) to insure the confidentiality and safety of the medical records of the persons they care for; and

WHEREAS, some facilities close operations, no longer retaining a state license to operate, and leave closed medical records behind; and

WHEREAS, the closed medical records which are orphaned could become data used to violate residents' privacy or for fraudulent purposes.

THEREFORE, BE IT RESOLVED that the federal and state governments assure adequate safeguarding and appropriate storage of all medical records of residents of a closed, previously licensed long-term care facility (be it an Assisted Living or Board and Care Facility or Nursing Home) until the proper date when they may meet a lawful disposition.

[1]Budget Reconciliation Act of 1990, Congressional Record, October 26, 1990, H12487

[2]www.hcfa.gov. "What's New," August 1, 2000 Report to Congress Appropriateness of minimum Nurse Staffing Ratios in Nursing Homes.