JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Statement of Eric Carlson
Directing Attorney, Justice in Aging

Committee on the Quality of Care in Nursing Homes
National Academies of Sciences, Engineering, and Medicine
Public Webinar #1
January 26, 2021

Thank you for the opportunity to speak to the Committee today. Nursing home quality deserves the careful attention that this Committee can provide.

Persistent Problems Caused by Nursing Homes Violating Existing Standards

I have represented nursing home residents and their interests for almost the entirety of my legal career. From 1991 through 2000, I served as Director of the Nursing Home Advocacy Project of Bet Tzedek Legal Services in Los Angeles. In that position, I directly represented facility residents in disputes with facilities and with the Medicare and Medicaid programs.

I continued my focus on nursing homes and other long-term services and supports when I began working for Justice in Aging[1] in 2001. As one part of my current job, I advise attorneys, ombudsman program representatives, and other aging network representatives on how to assist nursing home residents in accessing quality care. I also participate actively in policy advocacy on both the federal and state levels.

In one of my first weeks working in this field — in a scenario that I have observed numerous times since — a nursing home told an elderly resident that he had to move out immediately because his Medicare coverage had ended. When I called the facility on my new client's behalf, the facility immediately backtracked — but I have little doubt that they continued their unlawful practices against other residents.

Similar experiences followed, and I soon found that many nursing homes maintained business practices that directly conflicted with federal law. They were able to persist in these business practices because residents did not have the knowledge or the resources to fight back, and the survey process did not identify or adequately punish the violations. I began speaking on "Ten Falsehoods Told By Nursing Homes," and then observed and incorporated additional falsehoods as I continued representing residents. The current list includes 25 false statements.[2]

[1] Justice in Aging originally was called the National Senior Citizens Law Center; the name change occurred in 2015.
[2] Eric Carlson, Justice in Aging, 25 Common Nursing Home Problems – and How to Resolve Them (2019).

WASHINGTON
1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES
3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND
1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

Across my career, I have seen some overall improvement in nursing home care. That being said, many problems have persisted throughout those thirty years. The problems are attributable in large part to nursing home operators who are not truly committed to providing good care. In some cases, the offending nursing homes are generally (if not always publicly) recognized as bad actors.[3] In other instances, however, the offending facilities are not perceived as outliers — they represent a mediocre middle tier that is accepted as business-as-usual by both the provider community and by state and federal enforcement agencies.

The majority (or a large plurality) of nursing homes are in a state of constant non-compliance with many federal regulatory requirements. A small sample of common violations includes:

- Failing to maintain sufficient nursing staff.[4] Because the federal law sets no fixed minimums for staffing levels, facilities rarely are cited until after residents have been injured.
- Failing to maintain adequate infection prevention and control.[5] As the GAO recently reported, infection prevention and control violations have been the most commonly cited deficiency, with over 82 percent of facilities being cited for such a deficiency over a five-year period, and almost half of those cited facilities with violations in multiple consecutive years.[6]
- Lacking meaningful medical director services.[7] Under CMS guidance, medical directors must develop facility policies on resident care, coordinate medical care issues identified by the quality assessment and assurance committee, organize and coordinate physician services provided by other physicians, and work with the facility's clinical team to develop infection prevention policies.[8] In practice, many medical directors have only a nominal presence within nursing home operations.
- Providing lesser care based on a resident's payment source.[9] Payment-source discrimination is particularly visible when residents transition from Medicare to Medicaid coverage. During this transition, a resident's daily therapy often ends abruptly and completely. Also, many facilities at that time attempt to force the resident to leave the

[3] *See, e.g.*, Debbie Cenziper et al., *Profit and Pain: How California's Largest Nursing Home Chain Amassed Millions as Scrutiny Mounted*, Washington Post (Dec. 31, 2020) (Brius Healthcare).
[4] 42 C.F.R. § 483.35.
[5] 42 C.F.R. § 483.80.
[6] GAO, Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic, GAO-20-576R, at 4 (May 2020).
[7] 42 C.F.R. § 483.70(h).
[8] CMS, Appendix PP to State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, F-Tag F841, Guideline to 42 C.F.R. § 483.70(h).
[9] 42 C.F.R. § 483.10(a)(2).

facility entirely, claiming falsely that the nursing home does not provide "custodial" care.[10]

- Using antipsychotic medications for sedation.[11] Despite an FDA "black box" warning against use of antipsychotic medications for elderly persons with dementia, over fourteen percent of nursing home residents receive antipsychotic medication, with catastrophic results for many residents.[12]
- Failing to provide person-centered care.[13] This failure is telling. Particularly after a 2016 revision, the federal regulations heavily emphasize a nursing home's obligation "to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives."[14] In practice, however, most nursing homes act as if it is the resident's obligation to accommodate the facility's preferences, and not the reverse.

In short, many nursing homes follow business practices that put them in consistent noncompliance with federal nursing home law. In too many cases, this ongoing noncompliance leads directly to deaths, injuries, loss of function, and a deadening quality of life.

The current system allows such ongoing noncompliance. Any reforms should ensure that such noncompliance is sanctioned in a way that prevents it from continuing.

Answering Questions from the Committee

What is your perspective on the use of regulations to achieve quality care in nursing homes? Are more or less needed and why?

Based on my experiences, the federal regulations establish a strong foundation for high-quality nursing home. The ongoing systemic problem is not that the regulations measure the wrong factors, or are inconsistent with current nursing practices. Instead, problems persist because nursing homes are able to violate the law without meaningful sanction.

Federal nursing home law is based on solid nursing expertise — specifically, the Institute of Medicine's (IoM) 1986 report, *Improving the Quality of Care in Nursing Homes*. In perhaps its

[10] *See, e.g.*, State v. Neiswanger Mgmt. Servs., LLC, 179 A.3d 941, 947 (Md. Ct. App. 2018) (suit by Maryland Attorney General against chain of Maryland nursing homes, based on business practice of seeking residents' eviction immediately upon end of Medicare coverage).
[11] 42 C.F.R. §§ 483.10(e)(1), 483.45(e)(1).
[12] CMS, National Partnership to Improve Dementia Care in Nursing Homes: Antipsychotic Medication Use Data Report (October 2020) (data excludes residents diagnosed with schizophrenia, Huntington's Disease or Tourette's Syndrome); Human Rights Watch, *They Want Docile: How Nursing Homes in the United States Overmedicate People with Dementia* (Feb. 2018).
[13] 42 C.F.R. §§ 483.5, 483.10(c)(2), 483.21(b), 483.25.
[14] 42 C.F.R. § 483.5.

central finding, the IoM criticized the pre-1986 law's focus on a facility's capacity to provide services. The IoM instead advocated for focusing on results, so that evaluations would be based on whether facility residents actually received needed services.[15] That focus was enacted into law through the 1987 legislation and, shortly thereafter, in implementing regulations.[16] Less than five years ago, the regulations were brought up to date with an extensive revision that includes an increased focus on person-centeredness.[17]

Regarding the number of regulations, I respectfully suggest that "Are there too many regulations?" is the wrong question, because it is too easy for nursing home operators (or any other regulated entity) to bemoan in the aggregate the number of regulations. Any person who advocates for fewer regulations should be able to point to specific regulations that allegedly are inappropriate or unnecessary. Assuming, as is true in this case, that the regulatory system is based on solid principles, a broad claim of "too many regulations!" should not justify a baby-with-the bathwater rejection of the entire system. Instead, reformers should examine individual regulations to determine if any warrant elimination or reform.

Whenever these issues are discussed, provider representatives often present stories of facilities that allegedly have been cited for innocuous actions. Those stories deserve little weight. They generally are anecdotal and, in any case, involve violations that resulted in only a deficiency. When a facility is assessed a civil money penalty or other remedy, the violation invariably is linked to a shortcoming in resident care, and not to an allegedly "technical" violation.

Also, I encourage Committee members to not uncritically accept talking points about a supposedly "punitive" regulatory system, or of the value of a more "collaborative" system. The data show that the vast majority of deficiencies result in no remedy other than a plan of correction.[18] Indeed, the current system already is collaborative to a great extent, given the infrequent imposition of money penalties or other remedies, and the many resources made available through Quality Improvement Organizations (QIOs). To maintain the integrity and efficacy of the overall system, it is vital that survey agencies continue in their current role. Poor care must be cited and, when necessary, penalties imposed.

---

[15] Institute of Medicine, Improving the Quality of Care in Nursing Homes, at 78-79 (1986).
[16] Pub. L. No. 100-203, §§ 4201–4218, 101 Stat. 1330, 160–221 (1987) (enactment of law); *see* 56 Fed. Reg. 48,826 (1991) (Institute of Medicine report was genesis of Nursing Home Reform Law).
[17] 81 Fed. Reg. 68,688 (Oct. 4, 2016) (promulgating revised regulations); 42 C.F.R. § 483.5 (definition of person-centered care).
[18] GAO, Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic, GAO-20-576R, at 5-6 (May 2020).

What is your perspective on providing both long-term care services and transitional/sub-acute care in the same building? What impact (positive or negative) do these two very different care delivery models have on quality and might there be alternatives?

In my work, as discussed above, this issue appears most frequently in the payment-source discrimination occurring when a resident transitions from Medicare to Medicaid coverage. The co-location of transitional care and long-term care motivates facilities to prefer the former to the detriment of the latter, and to push out or otherwise discriminate against Medicaid-eligible persons requiring long-term care.

On the other hand, I do not see this co-location as a principal cause of substandard care. From my observations, poor care is not caused by a provider's inability to integrate transitional care with long-term care. Rather, poor care stems from short-staffing, inadequate training, and poor management.

Also, if transitional care were to be separated from long-term care, the quality of care in the latter could suffer. Federal law in the 1970s and 1980s authorized "skilled nursing facilities" and "intermediate care facilities" (ICF), but the IoM report found that the ICF's lower nurse staffing levels led to poorer care.[19] In response, the 1987 federal nursing home legislation eliminated the ICF category.[20] Similar to the ICF experience, separating transitional care from long-term care would run the risk of degrading resident care in the "long-term care facilities."

What is your perspective on how the care for residents is organized and delivered and the different types of nursing staff? What changes to how care is organized and delivered and who provides the care are needed, if any?

Certified nurse aides (CNAs) provide the bulk of direct care in a nursing home, but are underpaid and often divorced from decision-making processes. Improved pay and benefits are essential: in the words of a recent LeadingAge report, "paying at least a living wage could benefit care recipients, workers, and communities."[21] Also, CNAs should be provided with a realistic career ladder and integrated with the care team.[22] By giving CNAs more responsibility and influence, facilities can improve quality of care along with CNAs' expertise and job satisfaction.[23]

---

[19] Institute of Medicine, Improving the Quality of Care in Nursing Homes, at 73 (1986).
[20] Pub. L. No. 100-203, §§ 4201–4218, 101 Stat. 1330, 160–221 (1987).
[21] Christian Weller et al., LeadingAge, *Making Care Work Pay: How Paying at Least a Living Wage to Direct Care Workers Could Benefit Care Recipients, Workers, and Communities* (2020).
[22] Stephen Campbell et al., PHI, *Caring for the Future: The Power and Potential of America's Direct Care Workforce*, at 62-66 (Jan. 2021).
[23] E. Foy White-Chu et al., *Beyond the Medical Model: The Culture Change Revolution in Long-Term Care*, JAMDA, vol. 10, No. 6, at 370-378 (July 1, 2009); Robyn Stone et al., Evaluation of the Wellspring Model for Improving Nursing Home Quality (Aug. 2002).

What do you think is the most important recommendation our Committee could make that would impact the quality of care?

Short-staffing is the precipitating factor behind many instances of poor care. Malnutrition, pressure ulcers, incontinence episodes, infections, lack of socialization — all these problems often are attributable to a nurse aide being assigned too many residents, and not having enough time to truly attend to individual residents. Most recently, lower staffing levels have been found to correlate to facilities with greater COVID-19 problems.[24]

Thus, the Committee could have the greatest impact by setting solid staffing minimums. The current requirements — among other things, requiring an annual facility assessment and ongoing disclosure of staffing levels — have proven to be inadequate.[25]

As a complement or alternative to staffing minimums, the Committee could recommend a requirement that a facility devote a specified percentage of its revenue to direct care. One model is provided by recent New Jersey legislation that combined solid staffing requirements with an increase in Medicaid rates. The legislative package included:

- Mandatory minimum ratios for direct-care staffing;
- Increased minimum wage for direct-care staff members;
- Increased Medicaid reimbursement rate, with a requirement that a specified portion of the increase be spent on direct care;
- Strengthened visitation rules;
- State task force on nursing home quality and safety; and
- Long term care emergency operations center.[26]

In discussions about staffing levels, facility operators frequently blame allegedly inadequate Medicaid rates. Claims of supposedly inadequate rates, however, must be viewed with a

---

[24] Jose F. Figueroa et al., *Association of Nursing Home Ratings on Health Inspections, Quality of Care, and Nurse Staffing With COVID-19 Cases*, JAMA (Research Letter), vol. 324, no. 11, at 1103-1105 (Aug. 10, 2020); Rebecca J. Gorgees et al., *Staffing Levels and COVID-19 Cases and Outbreaks in US Nursing Homes*, J. Am. Geriatrics Society, vol. 68, at 2462-66 (Aug. 28, 2020) (higher nurse aide staffing and total nursing staff associated with lessened probability of outbreak, and fewer deaths); Charlene Harrington et al., *Nurse Staffing and Coronavirus Infections in California Nursing Homes*, Policy, Politics, & Nursing Practice, vol. 21, no. 3 (Aug. 1, 2020); Yue Li et al., *COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates*, J. Am. Geriatrics Society, vol. 68, at 1899-1906 (2020).

[25] *See* 42 C.F.R. §§ 483.(f) (posting of staffing levels), 483.70(e) (assessment).

[26] N.J. Public Law 2020, ch. 87 (emergency operations center), 88 (task force), 89 (required expenditures for direct care, increased minimum wage), 90 (increased Medicaid rate, with money designated for direct care), & 112 (minimum ratios for direct care); *see also* State of N.J., Governor Murphy Signs Legislative Package to Strengthen the Resiliency and Preparedness of New Jersey's Long-Term Care Industry (September 16, 2020).

jaundiced eye as long as nursing home operators continue to organize themselves through byzantine webs of parents, subsidiaries, management companies, landlords, REITs, and suppliers. Notably, these type of structures have little or no clinical justification. They exist only to evade legal responsibility and conceal financial reality.[27] To my knowledge, no other business in the country so routinely creates such complicated and deceptive operating structures.

The appropriateness of Medicaid rates cannot accurately be evaluated unless and until these dishonest organizational structures are prohibited. Past history suggests that even heightened disclosure requirements would not be enough, given the myriad ways that providers hide profit and evade responsibility.

[27] *See, e.g.*, Joseph Casson & Julia McMillen, Protecting Nursing Home Companies: Limiting Liability Through Corporate Restructuring, J. Health L., no. 36, at 577-613 (2003); Debbie Cenziper et al., *Profit and Pain: How California's Largest Nursing Home Chain Amassed Millions as Scrutiny Mounted*, Washington Post (Dec. 31, 2020).