

Senator Kohl
Attention: Ann Montgomery
Washington Office
(2nd and C St., NE)
330 Hart Senate Office Building
United States Senate
Washington, D.C. 20510

Re: Broken Promises II Report for the US Senate Special Committee on Aging
Testimonial Record

Dear Senator Kohl and Ms. Montgomery:

As you well know, this year marks the 20th Anniversary of the passage of the Omnibus Budget Reconciliation Act of 1987 (commonly referred to as OBRA '87). This landmark legislation provides federal standards for nursing home care and residents' rights. The Office of the D.C. Long-Term Care Ombudsman and Legal Counsel for the Elderly salutes your office, advocates, providers and others who worked tirelessly to write and pass this important piece of legislation in 1987, as well as maintaining its integrity throughout the years.

The Office of the D.C. Long-Term Care Ombudsman Program, supported and sponsored by Legal Counsel for the Elderly, would like to introduce its follow up report *Broken Promises II: An Assessment of the District of Columbia's Initiatives to Improve Quality of Care in Nursing Facilities, 2003 – 2005*, for the U. S. Senate Special Committee on Aging's testimonial record.

The D.C. Long-Term Care Ombudsman Program created and published "Broken Promises II" in response to our District's Department of Health inaction in implementing its 2002 quality of care initiatives. The goals of "Broken Promises" were to motivate positive change in the District's enforcement process, to recommend changes designed to improve care, and to stimulate action on the Department of Health's promised initiatives by providing a candid assess of District's performance. "Broken Promises II" concludes a four and half year regulatory enforcement and quality assurance study. It is our hope that this information will aid the Committee's tireless work in this vital arena.

If you have any questions or concerns regarding "Broken Promises II," please feel free to call me at 202-434-2140. I thank you for your time and look forward to working with the Committee in the future.

Sincerely,

Gerald Kasunic, Director
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Legal Counsel for the Elderly
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BROKEN PROMISES II

**An Assessment of the District of Columbia's Initiatives
to Improve Quality of Care in Nursing Facilities
2003-2005**

Prepared by

**The District of Columbia Long-Term Care
Ombudsman Program**

April 2006

BROKEN PROMISES II

An Assessment of the District of Columbia's Initiatives To Improve Quality of Care in the District's Nursing Facilities, 2003-2005

I. INTRODUCTION:

Under the Older Americans Act of 1965 and the District of Columbia's Long-Term Care Ombudsman Program Act of 1988, the Ombudsman Program is mandated to investigate and resolve complaints on behalf of residents in nursing homes, encourage citizens' involvement in improving nursing home quality, and monitor the development and implementation of regulations, laws and policies affecting nursing homes residents. In keeping with this mandate, the District of Columbia Office of the Long-Term Care Ombudsman, in November 2003, issued a report entitled "Broken Promises: An Interim Assessment of the District of Columbia's Initiatives to Improve Quality of Care in Nursing Facilities, 2002 – 2003." This report was prompted by the Ombudsman Program's concerns that D.C. nursing homes had serious quality of care problems and that the District of Columbia's Department of Health was failing to implement the District's nursing home regulations in a timely fashion, to properly enforce federal nursing home regulations, and, generally, to protect and promote the health and welfare of those residing in the District's long-term care facilities.

These concerns of the Ombudsman Program, and of other District organizations that advocate on behalf of the elderly and disabled, were expressed for a number of years both to officials at the D.C. Department of Health and to Congresswoman Eleanor Holmes Norton, who, in 2001, requested the Special Investigations Division of the Committee on Government Reform of the U.S. House of Representatives to prepare a report on nursing home care in the District of Columbia. A draft of that Congressional Report, Nursing Home Conditions in the District of Columbia: Many Homes Fail to Meet Federal Standards for Adequate Care, was provided to Mayor Williams and the D.C. Department of Health on November 26, 2001, prior to its public release, in order to give the District government time to prepare a response. On January 7, 2002, Congresswoman Norton officially released the report at a press conference held in conjunction with Mayor Williams and representatives of the Department of Health, who responded to the

report by announcing that D.C. nursing home regulations, which had been held in limbo, would finally be issued. In referring to the District's status as the only jurisdiction in the nation without regulations, Mayor Williams stated at the press conference: "This has got to be unacceptable to me, because it is certainly unacceptable to families of seniors." The Mayor went on to declare: "It's a sin and a crime not to have regulations."

In addition to its promise to immediately publish the nursing home regulations, the Department of Health distributed a document at the press conference, entitled "Initiatives to Improve Quality of Care in District of Columbia Nursing Facilities." In this document, the Department of Health promised, among other things, to:

- create "an enforcement mechanism to compel compliance" through "the use of citations for deficiencies and accompanying civil fines";
- "triple its surveyor staff to meet the need for increased monitoring of nursing facilities";
- further increase the nursing facility survey staff to form "an investigative/ complaint unit";
- develop a Disability and Aging Resource Center to "serve the dual function of empowering consumers to make informed choices about their long-term care options and creating a mechanism to assist in channeling individuals in need of long-term care to the most cost-effective setting";
- establish a "case-mix system" for nursing facility reimbursement by "October 2002"; and
- establish "a unit within MAA/ODA that will focus on continuous quality improvement," by "organizing and supplying training to providers and staff to improve the quality of care."

However, in the fall of 2003, almost two years after the District government assured its citizens that it was working to improve nursing home quality, the Ombudsman Program found that the D.C. Department of Health had failed to follow through on its promises:

- No implementation or enforcement of the District's January 2002 nursing home regulations had occurred.
- The surveyor staff was not tripled and no further increases in survey staff sufficient to form an investigative/complaint unit had occurred.

- Not one deficiency had been cited and not one penalty had been imposed against a nursing home on the basis of the January 2002 regulations.
- No Disability and Aging Resource Center has been developed.
- No case-mix system had been implemented.

In addition, an updated report by the Government Reform Committee of the U.S. House of Representatives on D.C. nursing home care, released by Congresswoman Norton on October 31, 2003, found that the quality of care in the District had not improved in the two years since its previous report was prepared and that serious problems continued to affect the health and welfare of D.C. nursing home residents.

In response to the Department of Health's inaction in implementing its 2002 initiatives and to the Congressional Report's findings of continued serious problems with care in the District's nursing facilities, the D.C. Long-Term Care Ombudsman Program issued "Broken Promises: An Interim Assessment of the District of Columbia's Initiatives to Improve Quality of Care in Nursing Facilities, 2002-2003." The goals of "Broken Promises" were to motivate positive change in the District's enforcement process, to recommend changes designed to improve care, and to stimulate action on the Department of Health's promised initiatives by providing a candid assessment of the District's performance in implementing the steps announced in January 2002 to improve nursing home care. Sadly, "Broken Promises" concluded that the District government had failed "to take its promises seriously and provide the leadership and funding necessary to fulfill them." At the same time, the Ombudsman Program issued its own promise to continue evaluating and assessing the progress made by the District government in implementing the 2002 initiatives and to issue another report if necessary.

In May 2005, "in response to Congresswoman Eleanor Holmes Norton's report on the quality of care provided in Nursing Facilities (NF) in the District of Columbia (District) released October 31, 2003," the D.C. Department of Health issued a second set of initiatives to improve D.C. nursing home care.¹ Similar to the initiatives issued in January 2002,² these "new"

¹ "Initiatives to Improve Quality of Care in District of Columbia Nursing Facilities," prepared by the District of Columbia Department of Health, Medical Assistance Administration in Coordination with the Health Regulation Administration, May 2005, p.2.

² See p.3 above.

initiatives, according to the Department of Health, were designed “to address quality concerns” and reflect “recommendations from the Institute of Medicine (IOM),”³ as follows:

- “Increasing survey efforts, especially for chronically poor performers, and increasing penalties for noncompliance”
- “Developing programs to disseminate information to consumers on the various types of long-term care settings available to them and the quality of individual providers”
- “Adjusting Medicaid reimbursement formulas for Nursing Facilities to take into account quality requirements and casemix-adjusted needs of residents”
- “Providing targeted training to address potentially problematic care trends and at-risk individuals”

However, based on the D.C. Long-Term Care Ombudsman Program’s monitoring and assessment of the quality of care in the District’s nursing homes from the end of 2003 through 2005 and of the steps taken and not taken by the D.C. Department of Health to fulfill its promises to improve long-term care in the District, this current report, “Broken Promises II,” finds that the District’s implementation of its May 2005 initiatives falls as short of success as its implementation of basically the same initiatives promised in January 2002.

II. APPROACH

Under federal law, the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS),⁴ contracts with the District of Columbia’s Department of Health, Health Regulation Administration (DOH, HRA), to conduct annual inspections of nursing homes and to investigate nursing home complaints. Through the use of the federal nursing home survey tool, known as the 2567 survey report, these inspections assess whether nursing homes are meeting the federal standards of care mandated for nursing homes to be certified for Medicaid and Medicare certification. These standards include providing appropriate staffing levels to meet the residents’ medical and psychosocial needs, maintaining an environment that is safe and secure, preventing injuries and accidents, and protecting residents’ rights, including their right to be free from abuse and neglect. Under state nursing home regulations, including those issued by the District in 2002, nursing homes must also meet the

³ DOH May 2005 “Initiatives,” pp.6-9.

⁴ Previously known as HCFA, the Health Care Financing Administration.

federal standards of care, but may have to meet higher standards in areas that a state decides is critical to safeguarding its nursing home residents.

Much like the D.C. Department of Health's Health Regulation Administration, the Office of the D.C. Long-Term Care Ombudsman, as mentioned above, is also federally and locally mandated to monitor, investigate, and work to resolve complaints about poor quality of care and quality of life in the District's nursing homes. The Office of the D.C. Long-Term Care Ombudsman fulfills its mandate through its Ombudsman staff and volunteers, who visit the District's nursing homes on a daily basis both to monitor care and investigate complaints received from residents, family and friends of nursing home residents, nursing home staff, community social workers and healthcare workers, and the general public. The Office of the D.C. Long-term Care Ombudsman collects and enters into its data system via a software program, OmbudsManager, all complaints received, all reports of monitoring visits and investigations conducted by Ombudsman staff and volunteers, and all referrals made by the Ombudsman Program to the Department of Health, Adult Protective Services, law enforcement, Medicare and Medicaid Fraud and Abuse agencies, etc., for further investigation and enforcement action.

Through OmbudsManager, the Ombudsman Program has reviewed and compared complaints reported to and investigated by Ombudsman Program staff and volunteers from 2003 through 2005.⁵ The Ombudsman Program staff compared the most recent nursing home survey data (2003 – 2005) with the past "Broken Promises" data (2002 – 2003) in order to document any complaint trends over the past two years.

In addition, the Ombudsman Program has reviewed and analyzed the nursing home survey inspection reports (Federal 2567 reports) completed by the D.C. Department of Health's Health Regulation Administration during the past two years and the nursing home surveys conducted by the Health Regulation Administration under the District's 2002 nursing home regulations. The Ombudsman Program has also reviewed the 2004 and 2005 cumulative complaints reported to the Ombudsman Program, examining the most recent information pertaining to 13 out of 20 nursing homes in Washington, D.C.⁶ Finally, the Ombudsman

⁵ All of the 2005 D.C. DOH, HRA survey data for the 13 nursing homes that the Ombudsman Program selected for review was not available during the research and drafting period of this report. The Ombudsman Program has used available data from Calendar Years 2003, 2004, and the first half of Calendar Year 2005 to produce this report

⁶ The thirteen nursing homes analyzed to create this report were chosen at random.

Program has compared the District's promised initiatives to improve quality of care – first presented in 2002 and then reissued with slight variation in May 2005 -- with the progress actually made in implementing these initiatives through reports and testimony to the City Council and first-hand experience collected through complaints made to the Ombudsman Program.

While the findings are representative of patterns of care and services received by residents of the District's nursing homes, conditions in individual nursing homes can change, and usually do, when new management or focused enforcement activities are conducted. For this reason, this report should be considered a snapshot in time of the nursing home care and enforcement activities that have emerged in the past two years.

III. FINDINGS

Overall, the Ombudsman Program has found that the Department of Health has not followed through on its promises, the outcomes of which remain uncertain. To date, the following remain true:

- Monitoring and regulation of the District's nursing homes for violations of Federal nursing home regulations have not improved due to the continued under-rating of nursing facility deficiencies and the failure to impose civil monetary penalties and other sanctions under federal guidelines;
- While the number of notices of infractions cited by HRA under the District's nursing home regulations has increased, the monetary fines imposed on nursing homes has not increased;
- A Disability and Aging Resource Center has been established, but it has not been fully funded and thus, has not been able to fulfill its original mandate of providing elderly and disabled residents with alternatives to nursing home care;
- A workable case-mix Medicaid payment methodology system for nursing facilities has not been fully implemented city-wide as promised, and;
- While the need for improved training of nursing home staff has been acknowledged, no new programs have been implemented that would improve services and increase the quality of care for D.C. residents.

A. INITIATIVE TO IMPROVE NURSING HOME ENFORCEMENT

1. Increasing Staff and Penalties

As noted earlier, in its January 2002 “Initiatives to Improve Quality of Care in District Nursing Facilities,” the D.C. Department of Health promised to:

- create “an enforcement mechanism to compel compliance” through “the use of citations for deficiencies and accompanying civil fines”
- “triple its surveyor staff to meet the need for increased monitoring of nursing facilities”
- further increase the nursing facility survey staff to form “an investigative/ complaint unit”

In its May 2005 “Initiatives to Improve Quality of Care in District Nursing Facilities,” the D.C. Department of Health presented as its first initiative:

- “Increasing survey efforts, especially for chronically poor performers, and increasing penalties for noncompliance.”

To date, however, these goals have not been achieved.

Although the Department of Health’s Health Regulation Administration (HRA), in December 2003, finally began to survey nursing facilities for deficiencies and to issue citations under the 2002 D.C. nursing facility regulations, its surveyor staff has not been tripled and “an investigative/complaint unit” has not been formed. **Since 2002, the number of HRA nursing home investigators on staff has fluctuated between five and seven; the current number of survey/complaint investigation staff is four.** It is, therefore, not surprising that the average response time by HRA to complaints filed by the Ombudsman Program in 2005 was **4.5 months** and that survey efforts, especially for chronically poor performers, and penalties for noncompliance have not increased.

In its May 2005 report, HRA stated that “most District NF’s were found to be in substantial compliance with local nursing home regulations” in 2004, yet the report goes on to say that more than half (55%) had deficiencies with the potential to harm residents and 45% had deficiencies causing actual harm to residents.⁷ In addition, in 2004, the Ombudsman Program logged **1296 complaints about nursing facility care**; and in 2005, after the number of nursing homes in the District decreased from 21 to 20, the Ombudsman Program received **1675 complaints about**

⁷ DOH May 2005 “Initiatives,” p.5.

care and services.⁸ Further, although the Health Regulation Administration issued an average of 12.8 deficiencies per facility for 2003, and an average of 18.2 deficiencies per facility for 2004,⁹ no federal monetary penalties or other sanctions have been imposed for these deficiencies since April 3, 2003.¹⁰

Despite the large numbers of complaints about nursing home care received by the Ombudsman Program in 2004 and 2005, fourteen nursing homes were issued 25 notices of infraction for only 34 violations of D.C. regulations, from December 2003 through December 2004, resulting in the collection of \$16,740.60 in monetary fines, with \$8,580 in monetary fines unpaid or pending in court.¹¹ From January 2005 through December 2005, eleven nursing homes were issued 26 notices of infraction for 39 violations, resulting in the collection of \$10,110 in fines, with \$11,425.00 unpaid/uncollected.¹² Although in 2004 and 2005, the Ombudsman Program received a total of 2,971 complaints from residents, family and friends of residents, ombudsman volunteers, nursing home and hospital staff, social workers, and others about the care and services being provided in the District's nursing homes, from December 2003 through December 2005, nursing facilities in the District paid a total of only \$26,850.60 in fines for only 73 cited violations of D.C. nursing facility regulations -- an average of \$367.82 per violation, many of which, as this report illustrates, posed a threat of harm to residents or actually resulted in harm.

⁸ Medstar Manor closed in the spring of 2004.

⁹ Cf. Charlene A. Harrington, Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1998 – 2004. Department of Social and Behavioral Sciences, University of California, San Francisco, August 8, 2005. Note: Charlene A. Harrington, Ph.D., R.N., F.A.A.N., Professor of Sociology in the Department of Social and Behavioral Sciences at the University of California, San Francisco, has served as Principal Investigator of several national long-term care research studies including the five-year National Evaluation of the Social/Health Maintenance Organizations (S/HMO) Demonstrations Projects for HCFA. Her areas of expertise include health care financing, legislation, policy analysis, and regulation and planning.

¹⁰ Cf. On HRA's website (http://doh.dc.gov/doh/cwp/view,a,1374,q,577174,dohNav_GID,1840.asp), the last monetary penalty imposed against a nursing home under federal survey guidelines \$4,875 against Hadley Skilled Unit. Requests to HRA and FOIA requests to CMS for a list of monetary penalties imposed on D.C. nursing facilities for violations of federal nursing facility regulations from April 2003 through December 2005 have been ignored. Since this information is supposed to be available to the public on HRA's website, as well as provided to the D.C. Long-Term Care Ombudsman Program under its Memorandum of Agreement with the D.C. Department of Health, the Ombudsman Program can only conclude that no monetary penalties for violations of federal nursing home regulations have been imposed by CMS since April 2003.

¹¹ This information was provided to the Ombudsman Program by the D.C. Department of Health on June 13, 2005.

¹² This information was provided to the Ombudsman Program by the D.C. Department of Health, Health Regulation Administration, on Feb. 16, 2006.

In its November 2003 “Broken Promises” report, the D.C. Long-Term Care Ombudsman Program took the Department of Health to task for imposing no monetary penalties for violations of D.C. nursing facility regulations and recommending only \$42,732.50 in civil monetary penalties between January 2002 and October 2003 for violations of federal nursing home regulations. Yet, the D.C. Department of Health, after promising, in January 2002, to increase survey and complaint investigation staff, and in May 2005, to increase penalties for noncompliance, imposed considerably less in monetary penalties for deficient nursing care under District nursing facility regulations between December 2003 and December 2005 than it did under federal regulations between January 2002 and October 2003. In addition, there is no indication that penalties or sanctions other than monetary fines -- such as licensure restrictions and withholding of payment -- have been imposed against substandard facilities during 2003-2005.

Without the imposition and collection of **serious federal and District** monetary penalties for substandard and life-threatening care, poor performing nursing homes have little incentive to improve their services or change their methods of operation. Given the fact that the highest fine imposed by HRA for a violation was \$2,860 and that, for the majority of violations, fines under \$1,000 were imposed, the District’s enforcement system encourages nursing facilities to simply pay the fine and continue the substandard performance that led to the fine, because fixing the problems resulting in harm to residents, such as hiring sufficient direct care staff, would cost many times more than even the highest fine. The result is that residents remain victims of poor care as the same violations are repeated year after year in the same facilities without correction.

2. Increasing Survey Efforts

In its November 2003 “Broken Promises” report, the D.C. Long-Term Care Ombudsman Program criticized the D.C. Department of Health for lax enforcement of federal nursing facility standards, as well as for failing to implement the D.C. nursing facility regulations that were issued in January 2002. Since then, as of December 2003, HRA began to cite nursing homes for violations of the D.C. nursing facility regulations. However, as noted above, the monetary penalties under D.C. regulations are minimal,¹³ do not reflect the seriousness of many of the

¹³ The schedule of fines for infractions of the D.C. nursing facility regulations go from \$50 for a Class 5 infraction to \$2,000 for a Class 1 infraction. 16 DCMR §3201.1 *et seq.*

violations, and will not deter nursing facilities from continuing to provide substandard care. One of the barriers to improving care continues to be HRA's interpretation and application of the D.C. nursing home regulations to violations. 16 DCMR 3201.2 states: "[a]n infraction shall be a repeat infraction and shall carry the enhanced penalties set forth in §3201.1." Yet, the Ombudsman Program, in its review of two fiscal years beginning in October of 2003 and ending in September of 2005, found not one citation that was labeled "enhanced" by HRA or recommended for daily compound fines.

In addition, the Ombudsman Program continues to have questions about the validity and quality of the nursing home surveys that HRA performs for CMS. These concerns are due not just to the apparent absence, since April 2003, of monetary fines or other sanctions imposed for violations of federal nursing facility standards, but also to continued under-rating by HRA surveyors of the scope and severity of deficiencies in District nursing homes.

As explained in the November 2003 "Broken Promises," under the federal nursing home regulatory system, every state and the District of Columbia has a contract with the Centers for Medicaid and Medicare Services (CMS), U.S. Department of Health and Human Services, to survey all nursing homes that receive Medicaid or Medicare funding to ensure compliance with minimal standards of care set by the Omnibus Reconciliation Act of 1987 (generally known as OBRA'87) and by the Nursing Home Reform Amendments of 1990. In the District, the Department of Health's Health Regulation Administration (HRA) is the agency funded by CMS to conduct surveys of District nursing homes to determine whether or not they meet federal standards of care. Surveyors use the following scope and severity grid developed by CMS to rate deficiencies:

**Assessment Factors used to Determine
The Seriousness of Deficiencies Matrix¹⁴**

Immediate jeopardy to resident health or safety	J PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	K PoC Required: Cat.: 3 Optional: Cat. 1 Optional: Cat. 2	L PoC Required: Cat. 3 Optional: Cat. 2 Optional: Cat. 1
Actual harm that is not immediate	G PoC Required: Cat 2. Optional: Cat. 1	H PoC Required: Cat 2 Optional: Cat 1	I PoC Required: Cat. 2 Optional: Temporary Mgmt.
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D PoC Required: Cat. 1 Optional: Cat. 2	E PoC Required: Cat. 1 Optional: Cat. 2	F PoC Required: Cat. 2 Optional: Cat. 1
No actual harm with potential for minimal harm	A PoC No remedies Commitment to Correct Not on CMS-52567	B PoC	C PoC
	Isolated	Pattern	Widespread

Substandard quality of care is any deficiency in 42 CFR 483.13, Resident Behaviors and Facility Practices, 42 CFR 483.13 Quality of Life, or 42 CFR 483.25, Quality of Care, that constitutes immediate jeopardy to resident health or safety; or a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm

Substantial compliance

POC: Plan of Correction(s)

Remedy Categories

Category 1 (Cat.1)

Directed Plan of Correction
State Monitor; and/or
Directed In-Service
Training

Category 2 (Cat.2)

Denial of Payment for New
Admissions
Denial of Payment for All Individuals
imposed by CMS; and/or
Civil money penalties:
\$50-\$3,000/day
\$1,000-\$10,000/instance

Category 3 (Cat.3)

Temp. Mgmt
Termination
Optional:
Civil money penalties
\$3,050-\$10,000/day
\$1,000-\$10,000/instance

¹⁴ Remedy categories and penalty definitions defining each scope and severity incident is on the following page.

Under CMS Guidelines, “A” violations are simply noted in the Federal 2567 survey reports with no response required from the nursing home. Violations rated from “B” to “F” require the nursing home to do nothing more than submit a plan of correction, although in certain cases (but so far not required in the District), a civil monetary penalty may be imposed for a “D” violation. Whether or not that plan of correction is actually implemented and actually corrects the violation is rarely addressed in the District. It should also be noted that a facility is considered “in substantial compliance” with federal standards if it receives no deficiencies above a “C,” (please refer to grid on the previous page) regardless of how many “A,” “B,” and “C” deficiencies are cited. Any violation rated a “G” or above may be recommended by the HRA for a civil monetary penalty in addition to a plan of correction. Other remedies are possible for deficiencies rated “G” and above, including (for “J” to “L” violations) denial of payment for new admissions, disqualification from Medicare and/or Medicaid payments, and placement of a receiver or temporary manager in the nursing home.

For this report, the Ombudsman Program analyzed the 2003 –2005 nursing home survey reports submitted to CMS by the Health Regulation Administration for 13 of the District’s 20 nursing facilities, chosen at random. The Ombudsman Program found that, from December 2003 to September 2005, eight of the thirteen facilities had been cited for 23 deficiencies that caused actual harm to nursing home residents, including fractured limbs not properly assessed by staff, preventable accidents, medication administration errors, and failure to report unusual incidents to the appropriate authorities. HRA rated 22 of these deficiencies at the “G” level. However, the Ombudsman Program has not found any evidence that the nursing homes cited received any federal monetary penalties or other sanctions. Further, in analyzing the deficiencies described in the survey reports for the thirteen facilities it reviewed, the Ombudsman Program staff found 49 that they would have rated at a higher scope and severity level than HRA rated them.

Admittedly, this problem of under-rating is not confined to HRA. A recent Government Accountability Office report (GAO-06-117), entitled “Nursing Home Quality and Safety Initiatives,” found that States fail to accurately report the injury and harm that nursing homes **affirmatively cause harm** to residents, that the agency contracted to survey the State’s nursing homes (e.g., HRA in the District) "allows homes to conceal problems...", and that "state inspections ... understated the extent of serious quality-of-care problems, reflecting ... inconsistent application of federal standards." The report also found that "[n]ursing homes

repeatedly caused **actual harm** to residents, such as worsening pressure sores or untreated weight loss, or placed residents at **risk of death or serious injury**" and that "**serious complaints** by residents, family members, or staff alleging **harm** to residents remained **uninvestigated for weeks or months....**" ¹⁵ Finally, the report states that CMS acknowledges that (1) nursing home State surveys under-rate what inspectors find and report by 8 to 33 percent, and (2) there is an "increase in such discrepancies [between what a State admits and what CMS finds when it surveys the same nursing homes] from 22 to 28 percent." Clearly, when violations of care standards under the federal system are under-rated, federal penalties or sanctions are not imposed and poor performing nursing homes continue to put residents at risk of injury and even death. While under-rating of deficiencies is a problem nationwide, HRA continues to be part of that problem. The following pages provide some examples of the ratings issued by HRA for deficiencies identified in nursing home surveys performed for CMS during 2003-2005. The D.C. Long-Term Care Ombudsman Program provides a comment section assessing the ratings given by the HRA to the deficiencies described.

Examples

Violation: Failure to notify a physician after blood was found in the diaper of one resident and failure to notify physician of pressure sore development.

HRA Rating: **D** (isolated incident; potential for more than minimal harm)

Ombudsman Program Rating: **G**, because presence of blood and development of pressure sores reflect actual harm to a resident.

Violation: Failure to monitor a resident's glucose level as ordered by a physician; failure to obtain weekly blood pressure as ordered; failure to give insulin coverage for elevated fingerstick results as ordered; failure to test glucose as well as administer insulin; plus seven other deficiencies in resident assessment.

HRA Rating: **E** (pattern; potential for more than minimal harm)

Ombudsman Program Rating: **H**, because deficiencies affecting 11 of 13 residents sampled indicate widespread harm and failure to monitor the glucose levels of diabetics and provide insulin ordered by a physician put these residents in immediate jeopardy to residents' health and safety.

Violation: Failure to assess a resident for pain complaints during wound care; failure to assess a resident for abdominal pain complaints; failure to follow up on abnormal albumin levels for a resident; failure to obtain weekly blood pressure for resident on Lasix; failure to administer insulin coverage for two residents; failure to assess pressure sore; as well as five other deficiencies in resident assessment.

¹⁵ Emphasis added in bold.

HRA Rating: E (pattern; potential for more than minimal harm)

Ombudsman Program Rating: H, because the deficiencies in medical care were widespread and posed an immediate danger to residents' health and safety.

Violation: Failure to identify stage 3 pressure sore development on leg and failure to promote healing of stage 1 pressure sore on heel of resident; failure to identify stage 3 sacrum pressure sore on resident; failure to follow orders for positioning and use clean technique during wound treatment on a resident.

HRA Rating: G (isolated; actual harm to health/safety)

Ombudsman Program Rating: I, because the failures of care were found in 3 of five residents sampled and were therefore widespread.

Violation: Failure to obtain K+ levels for resident on Lasix as ordered; failure to follow up on a request for an x-ray for a resident who was later determined to have a fractured hip; along with four other deficiencies in physician services.

HRA Rating: C (widespread; no actual harm; facility in substantial compliance)

Ombudsman Program Rating: F, because substandard medical care provided to 6 of 30 residents sampled indicates widespread potential harm.

Violation: Hand mitts applied to prevent resident from pulling/eating dressing materials with no evidence that interventions other than physical restraints were used; resident with six falls over four months; three other violations of physical restraints regulations.¹⁶

Rating: C (widespread; no actual harm; facility in substantial compliance)

Ombudsman Program Rating: F, because restraint violations have the potential to harm residents and violations for 5 of 30 residents sampled indicates a pattern for potential for harm.

Violation: Dental consultation recommended extraction of two teeth but no follow-up was done and resident had continual pain/facial swelling and poor (food) intake until teeth were finally extracted; no follow-up for post surgical evaluation of resident following emergency surgery for ischemic bowel with obstruction; no follow-up for recommended GYN/ONC appointment for resident found to have cancer in pelvis; improper transcription of order for Prosource for resident with low albumin, none received for a month and improper lower amount given for a month; no psychiatric consultation obtained for five months despite social service urgent recommendation for resident subsequently started on antidepressant and dementia medications; no chart record of metabolic panel drawn five months earlier for resident found to have blood sugar of 233mg/dL

¹⁶ HRA claims in its 2005 "initiatives to Improve Quality Care in the District of Columbia," cited *supra* (p.6), that "[t]he District has strict regulations regarding the use of restraints." However, the current District regulations regarding the use of physical and chemical restraints do not comply with Federal regulations and do not go far enough to eliminate the abuse of physical and chemical restraints. For example, 22 DCMR §3216.1 simply states, "[e]ach resident has the right to be free from unnecessary physical and chemical restraints." Because "unnecessary" is not defined in the regulations, the term is open to interpretation by the nursing facility. In contrast, the federal regulation, 42 CFR § 483.13(a) states, "[t]he resident has the right to be free from any physical or chemical restraint imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms." The federal regulations are more restrictive and thus, more protective against abuse. In addition, DCMR §3216.4 allows for a registered nurse to administer restraints in emergency situations in violation of federal regulation 42 U.S.C. 1396r (c)(1)(A)(11), which clearly states "only physicians can order physical or chemical restraints" (emphasis added).

and started on oral hypoglycemic; coumadin order transcribed incorrectly and no evidence it was given for a period of twelve days in February; eighteen other deficiencies in resident assessment and quality of care.

HRA Rating: G (isolated; actual harm to health/safety)

Ombudsman Program Rating: L, because serious deficiencies in medical care for 18 of 30 residents sampled and 5 of 20 supplemental residents sampled indicate that the health and safety of residents in this nursing facility were in widespread and immediate danger.

Violation: Insufficient nursing staff to implement professional standards of care, resulting in the deficiencies directly above.

HRA Rating: E (pattern; potential for more than minimal harm)

Ombudsman Program Rating: L, because serious deficiencies medical care for 18 of 30 residents sampled and 5 of 20 supplemental residents sampled indicate that the health and safety of residents in this nursing facility were in widespread and immediate danger as a direct result of the lack of staffing.

Violation: X-ray performed 24 hr. after resident exhibited abdominal pain/vomiting showed small bowel obstruction, yet another 24 hr. lapsed with no treatment or evaluation by attending physician evaluation by attending physician or member of medical team at nursing facility or member of medical team; on 3rd day after vomiting began, resident was admitted to the hospital for emergency bowel resection; these and 6 more deficiencies in physician services found.

HRA Rating: G (isolated; actual harm to health/safety)

Ombudsman Program Rating: J, because resident requiring bowel resection for obstruction following three days of vomiting/pain with out a medical evaluation was in immediate jeopardy.

Violation: Nine wheelchairs soiled on three floors; twelve exhaust vents dirty on four floors; twenty-six doors soiled/marred throughout building; floors sticky and not clean in eight rooms; personal items stored in disorderly manner in storage rooms; walls damaged behind beds in nine rooms; soiled linen rooms; ceiling tiles stained/ill-fitting in sixteen areas; baseboards separated from wall surfaces; strong urine odors in area around two rooms; water accumulated on floor following shower; window sills damaged in six rooms; improper use of clothes dryers, and other environmental deficiencies.

HRA Rating: E (pattern potential for more than minimal harm)

Ombudsman Program Rating: F, because deficiencies were widespread throughout the facility.

Violation: Delay of twenty-four hours in transporting a resident, with a temperature of 104 to the emergency room.

HRA Rating: G (isolated; actual harm to health/safety)

Ombudsman Program Rating: J, because this failure in care posed an immediate danger to the resident's health.

Violation: Failure to investigate hospital acquired infections, no tracking reports to determine mode of transmission, failure to analyze data pertaining to urinary tract infections.

HRA Rating: D (isolated incident; potential for more than minimal harm)

Ombudsman Program Rating: H, because unsanitary practices affect all residents in the facility.

Violation: Failure of dentist to perform follow up visit on a resident with pain/decaying teeth whose tooth subsequently broke off.

HRA Rating: **D** (isolated incident; potential for more than minimal harm)

Ombudsman Program Rating: **G**, because actual harm, the loss of the tooth, was a result of deficient dental services.

Violation: Failure to provide adequate supervision for resident with a history of seizures and unsteady gait who fell in room, resulting in emergency transfer to hospital for bruises and unresponsiveness.

DOH/HRA Rating: **D** (isolated incident; potential for more than minimal harm)

Ombudsman Program Rating: **G**, because the resident suffered actual harm and injury as a result of this deficiency in care.

Violation: Failure to assess/identify a fractured elbow for 3 days while resident complained of pain/yelled/grimaced, exhibited swelling/bruising; x-rays inaccurately interpreted and blood tests ordered by physician for that resident failed to be performed; failure to insert suprapubic catheter/wrong size inserted for a resident; as well as seven other deficiencies in resident assessment and quality of care.

HRA Rating: **G** (isolated; actual harm to health/safety)

Ombudsman Program Rating: **H or I**, because deficiencies show at least a pattern of poor care and possibly widespread poor care resulting in actual harm to residents.

Violation: Call Cell Boxes in shower lacked plastic covers, have damaged/broken switches and are missing pull cords on three floors.

HRA Rating: **C** (widespread; no actual harm; facility in substantial compliance)

Ombudsman Program Rating: **F**, because residents' inability to alert staff of an emergency in the shower room has the potential for more than minimal harm and affects all residents who shower in that facility.

Violation: Failure to provide adequate assistance during transfer of resident from bed to chair resulting in elbow fracture for a resident whose Minimum Data Set (MDS)¹⁷ stated the resident required at least 2 persons for physical assistance with transfers; another resident who has physical functioning/structural problems and requires at least 2 persons for transfer fell during transfer from bed to shower chair.

HRA Rating: **G** (isolated; actual harm to health/safety)

Ombudsman Program Rating: **H**, because if this failure occurred with two of the sampled residents, a pattern of actual harm is indicated.

¹⁷ The federal government requires that nursing homes receiving Medicaid and Medicare funds prepare a comprehensive assessment, known as the Minimum Data Set (MDS), for every resident upon admission to the nursing home and periodically thereafter. The MDS assessment of the resident's medical, social, psychiatric, nutritional, and functional status is then used to determine the resident's care needs and to create a plan of care to meet those needs.

Violation: Resident twice physically assaulted, hit in face, by another resident with history of prior assaults; another resident hit in head by another resident with wheelchair pedal, laceration required 9 staples.

DOH/HRA Rating: **G** (isolated; actual harm to health/safety)

Ombudsman Program Rating: **H**, because incidents show pattern of harm.

Violation: Resident assessed as “no problems with behavior” despite three episodes-- throwing coffee at nurse aide, hitting another resident in head four times with a cane, and striking another resident in the leg with a cane.

HRA Rating: **D** (isolated incident; potential for more than minimal harm)

Ombudsman Program Rating: **I**, because actual harm was caused and resident engaged in a pattern of harmful behavior without appropriate intervention by nursing facility.

Violation: Fracture of resident’s tibia/fibula when nursing assistant used wrong lift to transfer resident; 11 of 30 residents sampled and 8 of 10 supplemental residents experienced basic deficiencies in care.

HRA Rating: **G** (isolated; actual harm to health/safety)

Ombudsman Program Rating: **I**, because widespread failure in care was found.

As in “Broken Promises 2002 -2003,” this report finds that HRA’s regulatory enforcement is not strong enough to ensure that serious deficiencies are corrected and repeat poor performers are deterred from providing substandard care and services to the District’s nursing home residents.

3. Increasing Monitoring of Poor Performers

From its analysis of the Health Regulation Administration’s surveys, the Ombudsman Program found that another major reason for the lack of progress in improving nursing home care is the ineffective monitoring by HRA of plans of correction provided by the nursing homes in response to deficiency citations. The Ombudsman Program has seen plans of correction that are almost indistinguishable from year to year for the same deficiencies in the same nursing homes.¹⁸ As the Ombudsman program has repeatedly argued, it is critical that a nursing facility be given a specific and reasonable date by which to correct the violations found by HRA and that an inspector be assigned to reinspect -- and be held accountable for reinspecting -- by the

¹⁸ Between December 2003 and December 2005, for example, one nursing home was cited for the same violations in February and April 2005 and for another same violation in January, March, August, and November 2005; another nursing home was cited for the same violation in July and October 2004 and another same violation in January and March 2005; a third nursing home was cited for the same violation in June 2004, July 2004, and August 2005 and for another same violation in April and August 2005; two other nursing homes were cited for the same violation in successive months.

required date. In addition, HRA must issue compound fining of a facility for the repeat offenses that are not corrected by the date(s) specified. The following examples illustrate deficiencies that were described in “Broken Promises 2002-2003” and found to be recurring during the 2003-2005 surveys without correction:

Violation: Inadequate care plans to provide for resident’s needs, e.g., no plan to monitor elopement for resident with dementia; no plan to prevent resident from wandering into room of another who had history of physical aggression towards that resident; medications discontinued and begun for a resident without precautions for medications documented; failure to document that resident’s position was to be changed every two hours to prevent worsening of pressure ulcer(s); failure to plan interventions for behaviors of resident resisting care.

Plan of Correction: Update resident care plans; monitor residents; assess care plans.

Comment: 13 of the 13 nursing home surveys reviewed for this report contained similar, if not identical deficiencies in resident care plans as those noted “Broken Promises, 2002-2003.”

Violation: Hot water valves/pumps not operating effectively; hot water is too cold, e.g., 84-98 degrees F., 78-108 degrees F., 68-100 degrees F. instead of the 110 degrees F. required for baths/showers.

Plan of Correction: Inspected system to determine replacement needs.

Comment: This deficiency was noted in “Broken Promises, 2002-2003,” so the inspection plan failed to lead to correction.

Violation: The facility failed to provide necessary care and services as evidenced by the failure to administer insulin when a resident’s blood sugar levels required insulin to be given and failure to provide the correct dose of insulin on two occasions.

Plan of Correction: Prepare insulin error report.

Comment: This deficiency was noted in “Broken Promises, 2002-2003,” so the plan of correction either failed to correct the problem or was never implemented. Additionally, all 13 homes reviewed for this report were cited for deficiencies in providing correct dosages of medicine to residents and in administering medicine and medical procedures as ordered/required, putting residents’ health in jeopardy.

Violation: Failure to comply with the Life Safety Code Standard to ensure resident safety in the event of a fire, e.g., failure to document fire alarm system testing, failure to ensure that double doors locked and closed to prevent the passage of smoke in the event of a fire, smoke barrier walls above ceiling tiles not in good condition to prevent passage of smoke.

Plan of Correction: Check and replace deficient fire doors.

Comment: This deficiency was noted in “Broken Promises, 2002-2003,” so the plan of correction either failed to correct the problem or was never implemented. Additionally, this deficiency was cited for 9 nursing facilities in 2003-2004, and a number of facilities have been cited for this deficiency every year from 2002 to 2004.

B. INITIATIVE TO DEVELOP AGING & DISABILITY RESOURCE CENTER

In 2002, the D.C. Department of Health's Medical Assistance Administration (MAA) was successful in receiving \$2.1 million dollars in federal grant funds to develop home and community based services waiver programs and an Aging and Disability Resource Center in the District. These programs are designed to provide elderly and disabled persons with options to receive long-term care services at home or in a community-based residence instead of in a nursing home. The then-Director of MAA recognized that many States had for years been developing one-stop long-term care service centers and related programs to keep the elderly and persons with disabilities at home and independent as long as possible, not only to improve their quality of life but also to save on the enormous and ever rising costs of nursing home care. The District, in contrast, has provided these residents with little or no alternative to institutionalization for long-term care.

In its January 2002 "Initiatives to Improve Quality Care in District of Columbia Nursing Facilities," then, the D.C. Department of Health promised to develop a Disability and Aging Resource Center to "serve the dual function of empowering consumers to make informed choices about their long-term care options and creating a mechanism to assist in channeling individuals in need of long-term care to the most cost-effective setting." However, the Ombudsman Program noted in its 2003 "Broken Promises" report, that as of November 2003, MAA had failed to create the Resource Center and to fully implement the home and community based Medicaid waivers to assist the elderly and disabled.

In its May 2005 "Initiatives to Improve Quality Care in District of Columbia Nursing Facilities," the D.C. Department of Health again listed as its second major initiative: "Developing programs to disseminate information to consumers on the various types of long-term care settings available to them and the quality of individual providers." DOH went on to repeat the statements in its January 2002 report that the Center "will serve the dual function of empowering consumers to make informed choices about their long-term care options and creating a mechanism to assist in channeling individuals in need of long-term care to the most cost-effective setting" through a "comprehensive interdisciplinary program" of "screening and assessment and counseling services" to ensure that D.C. residents needing long-term care will have options other than institutionalization. However, the District Aging and Disabilities Resource Center that began operations in December 2004 lacked the funding that CMS had

previously approved and granted. Because the funding had been substantially reduced, the Center has lacked the resources to provide the services originally envisioned.

Consequently, despite DOH's claims in its January 2002 and May 2005 reports about the services and options that the Center would and had provided, a D.C. Council task force¹⁹ reported in December 2005 that the District "has failed to use available federal funds to keep elderly residents out of nursing homes, spends disproportionate dollars on institutional care instead of home and community support, and . . . has a regulatory system that does not assure that these vulnerable people will receive high-quality services no matter what the setting."²⁰ In particular, the 17-person task force's report focused on "the confusion and the paucity of information" that limits the options of the elderly and persons with disabilities and results in their "unnecessary placement" in institutional care, and it called for "much more public outreach and coordination among professionals."²¹ The failures found by the D.C. Council task force are those that the Center was developed to correct, and the recommendations made in the report are those that the Ombudsman Program and other aging and disability advocates have been requesting since 2003.

C. INITIATIVE TO ESTABLISH A CASEMIX SYSTEM

In its January 2002 "Initiatives to Improve Quality Care in District of Columbia Nursing Facilities," the D.C. Department of Health stated as its third major initiative: "Adjusting Medicaid reimbursement formulas for Nursing Facilities to take into account quality requirements and casemix-adjusted needs of residents" by October 2002. In discussing implementation of a casemix system, DOH went on to say that it "has recognized that the current methodology the District uses to establish Medicaid rates for nursing facilities fails to encourage quality care, especially for the most vulnerable District residents," that the current rate methodology acted as "a barrier to the provider ability to give adequate care for individuals with greater needs," and that the current rate "creates a strong incentive" to keep individuals in nursing homes who could potentially be served through home and community based services.

¹⁹ Jerry Kasunic, Director of the D.C. Long-Term Care Ombudsman Office, served on the task forces for both the Access and Quality of Care Subcommittees.

²⁰ Susan Levine, "Panel Urges Changes in Elderly Care," *The Washington Post*, December 1, 2005, District, p.3 .

²¹ *Ibid.*

Despite DOH's recognition of the problems with its current nursing home payment system, by November 2003, when the Ombudsman Program issued its first "Broken Promises" report, a casemix system of nursing home reimbursement had not been implemented.

In its May 2005 "Initiatives to Improve Quality Care in District of Columbia Nursing Facilities," the D.C. Department of Health again presented establishment of a casemix system as its third initiative, repeating word for word the comments that appeared in the January 2002 "Initiatives" about the problems with the current system and the advantages of the casemix system. The only difference between the two discussions of this initiative is that in the May 2005 report, the implementation date for the new casemix system was given as "Summer 2005," rather than "October 2002." However, to date, the D.C. Department of Health and the City Council has passed legislation (January 2006) in order to create and implement a casemix system, but casemix has yet to be fully implemented and providers, presumably, continue to lack encouragement to provide quality care.²²

D. INITIATIVE TO PROVIDE TRAINING TO IMPROVE QUALITY OF CARE

In both its January 2002 and May 2005 "Initiatives to Improve Quality Care in District of Columbia Nursing Facilities," the D.C. Department of Health listed as its fourth initiative: "Providing targeted training to address potentially problematic care trends and at-risk individuals." Both reports stated, "To achieve this goal, DOH is seeking funds to accomplish the following goals," which in both reports include: (1) Establishing a unit within the D.C. Medical Assistance Administration's Office on Disability and Aging that will, among other things, "focus on continuous quality improvement" by "proactively identifying individuals potentially at risk," "working to ensure that plans of correction are implemented and resident outcomes improved"; (2) Providing training to providers and staff "to improve the quality of care"; and (3) Extending the Delmarva Foundation's²³ scope of work to include "additional training targeted to providers for whom quality concerns have been identified. The fact that the same goals are stated in exactly the same words in DOH's 2002 and 2005 "Initiatives" clearly demonstrates that no

²² Changes were made to the proposed casemix system in the Notice of Final Rulemaking, February 24, 2006 amending 29 DCMR 6500 (53 DCR 1350), but no clear acuity definitions and reimbursement processes has occurred.

²³ The D.C. Department of Health contracts with the Delmarva Foundation to assess an individual's initial and continuing medical eligibility for nursing home services under Medicaid/Medicare.

progress was made by DOH in implementing the goals of this initiative between January 2002 and May 2005.

Nevertheless, in its discussion in its 2005 report of its first initiative for improving quality care, i.e., increasing survey efforts, DOH mentions that it had recently restructured its contract with the Delmarva Foundation “to include a significant quality improvement component.” As explained by DOH, Delmarva Foundation now validates the MDS data²⁴ self-reported by nursing homes “by comparing it to independent resident assessments and medical record reviews and identifying clinical flags that could suggest a quality concern.” If a resident is flagged by this method, “a Delmarva review nurse will conduct an in-person assessment and medical record review” followed by a report to MAA, which “will then determine whether to work with the facility to address the concern or to forward it to the Health Regulation Administration (HRA) for sanction.”

While supporting DOH’s initiatives to improve nursing home care, the Ombudsman Program has concerns about the value to be derived from the expenditure of funds for Delmarva’s added duties, as described above. To begin with, a recent report for the National Commission for Quality Long-Term Care²⁵ notes that “the use of the MDS outcome-based data for ranking and comparing facilities is still controversial” and that researchers have had concerns about the Outcome-Based Quality Indicators (OBQI) approach to quality assurance, on which the MDS is based -- in particular, its validity and reliability in practice, i.e., in “real world” situations.²⁶ The report goes on to say that researchers have found not only that “the relationship between quality indicators and quality care is too complex to be captured in the MDS” but also that “there may be perverse incentives and counterproductive conclusions drawn from MDS data and associated QIs [Quality Indicators].”²⁷ Further, the report states that little evidence exists to

²⁴ The MDS, or Minimum Data Set, is the tool that CMS requires nursing homes to use to assess residents when they enter a nursing home to determine their functional, physical, mental, nutritional, recreational, and psychosocial needs. The resident’s plan of care is then developed from the MDS data.

²⁵ John Capitman, et al., “Long-term Care Quality: Historical Overview and Current Initiatives,” National Commission for Quality Long-Term Care, 2005 (<http://www.qualitylongtermcarecommission.org/reports>).

²⁶ Similarly, in an article in the September 2005 issue of *The Gerontologist*, three prominent researchers at the Borum Center of Gerontological Research at UCLA concluded that direct observation of care delivery should be adopted as a means of evaluating nursing home quality because observational data “provide one of the few sources of information about care that is independent of staff self-reports” which are often filled with inaccuracies. The MDS is the primary self-reporting tool used by Delmarva to measure nursing home quality.

²⁷ A study of the uses of the MDS indicated that the better facilities are at evaluating and documenting care problems, the worse the facilities may appear on the QI scale. For example, nursing homes rated as having high

directly link “the implementation of MDS to patient outcomes and satisfaction,” and that sharing data on QI performance with providers “does not necessarily lead to improvements in care processes.” Finally, the report points out that the medical approach of the MDS system fails to include “attention to patient autonomy and quality of life”; instead it “makes specific tasks and avoidance of mistakes the focus of facilities, rather than the needs and wants of individual people in their care.”

In addition to concerns that resident care will not be improved as a result of Delmarva’s enhanced focus on the MDS, the Ombudsman Program also believes that any positive outcomes for residents that could result from Delmarva’s new tasks will be diminished by Delmarva’s lack of cooperation with the Ombudsman Program and other long-term care advocates and failure to communicate its findings to these groups to better protect long-term care residents and improve their quality of care and quality of life. Finally, the Ombudsman Program believes that the funds being used for Delmarva’s enhanced MDS duties would, in the short run, be better used in (1) increasing the number of HRA surveyors to ensure that plans of corrections submitted by nursing homes in response to deficiencies are implemented, (2) establishing the long-promised complaint investigation unit in HRA so that complaints of potential, actual, and imminent harm to residents are investigated in a timely manner and steps taken to ensure that the nursing home’s policies, practices, and conditions are timely changed/corrected to prevent harm to additional residents; and (3) promoting and supporting “culture change” in the District’s nursing homes.²⁸

IV. OMBUDSMAN PROGRAM RECOMMENDATIONS

The quality of nursing home care in the District of Columbia continues to be a serious problem that will only worsen unless the Department of Health takes immediate action to fulfill the promises made in January 2002 and reiterated in May 2005. For DOH to successfully meet the stated goals of its four major initiatives, the Ombudsman Program recommends that the District government take following steps:

prevalence of pain were more likely to assess and treat residents’ pain appropriately than nursing homes rated as having low prevalence of pain.

²⁸ Section IV, following, “Ombudsman Program Recommendation,” explains the concept of “culture change” in the nursing home context.

A. Monitoring and Enforcement

DOH must expand and train its nursing home survey and complaint investigation staff to strictly enforce District and federal nursing home regulations, impose appropriate fines and sanctions for infractions, and ensure compliance with penalties imposed by monitoring the implementation of plans of correction and payment of all monetary penalties imposed. At the same time, as stated in its 2003 “Broken Promises,” the Ombudsman Program strongly believes that the enforcement mechanism designed to compel compliance with the District’s 2002 nursing home regulations must be something more than simply a schedule of fines. To be effective in improving the quality of nursing home care and services, **the remedy for a nursing home deficiency cannot simply be a civil monetary penalty.** Further, the Ombudsman Program has consistently recommended to the Department of Health that, at the very least, schedule of fines adopted to compel compliance with the District’s 2002 nursing home regulations should classify violations of 22 DCMR 3200 *et seq.* as follows:

- a violation that causes actual physical or emotional/psychological harm to a resident be classified as a Class 1 infraction;
- a violation that poses an imminent danger to a resident’s health, safety, or welfare or that abridges a resident’s right to freedom from neglect, exploitation, or physical, mental, verbal, or sexual abuse be classified as a Class 2 infraction; and
- a violation that impacts a resident’s health, safety, or welfare, but does not pose an imminent risk of harm, be classified as a Class 3 infraction.

The Ombudsman Program also strongly opposes an enforcement system that provides a civil monetary penalty alone as a remedy to poor care. Merely imposing a fine is not enough to ensure compliance, especially when the amounts of the fines are so low that paying them is much less costly than correcting the deficiency. A plan of correction, as well as a civil monetary penalty, should be required for infractions of the 2002 District nursing home rules. However, **when a plan of correction is required, it is critical that the facility be given a specific and reasonable date by which to correct the violation and that an inspector be assigned to reinspect, and be held accountable for reinspecting, on the date specified for correction.** If the deficiency is not corrected by the date specified, compound fining of the facility for a repeat offense should immediately commence. Thus, 16 DCMR 3201.2 should also be amended to provide that each day of violation following the day by which the violation is required to be

corrected should constitute a separate, repeat infraction and be fined as such. This change is important to ensure the imposition of strict, timely, and appropriate plans of correction on facilities.

In addition, the Ombudsman Program believes that, as in other jurisdictions, additional remedies be included in the enforcement scheme, such as the imposition of staffing ratios, hiring of specialists to train staff, placement of a receiver or new management team, and denial of new admissions. Similarly, as in other jurisdictions, the Ombudsman Program recommends that the fines collected for infractions be kept in a separate fund designated for hiring and training additional inspectors, hiring receivers/monitors for substandard facilities, making emergency repairs, and hiring additional staff to prevent imminent harm to residents when facilities fail to act -- the cost of which would then be subtracted from the Medicaid and Medicare payments to the facilities from the District. In Maryland, for example, the “Nursing Homes – Quality Assurance” bill, passed in 2000, not only increases fines for nursing home violations, but also provides as follows:

. . . the amount of the penalty imposed, together with any accrued interest, shall be placed in a fund to be established by the Secretary and shall be applied exclusively for the protection of the health or property of residents of nursing homes that have been found to have deficiencies, including payment for the costs of relocation of residents to other homes, maintenance or operation of a nursing home pending corrections of deficiencies or closure, and reimbursement of residents for personal funds lost.

Similar language establishing a fund for fines paid by District nursing homes should be added to the regulations enforcing the District’s 2002 nursing home rules.²⁹

Finally, the Ombudsman Program recommends that the Department of Health create a long-term care task force to focus on chronically poor performers and make annual survey reports on these offenders available to the public.³⁰

²⁹ A “Survey of State Use of Civil Monetary Penalties and State Fines,” conducted by Charlene Harrington and Theo Tsoukalas, University of California at San Francisco, and Cynthia Rudder, Long Term Care Community Coalition, funded by the Commonwealth Fund, and presented at the annual meeting of the National Citizens’ Coalition for Nursing Home Reform, in October 2005, found that **only six states, the District of Columbia being one of the six,** have no separate account for funds collected from federal and state fines for nursing home violations. Thirty-five states at the time of the survey had almost \$56 million available in accounts from federal and state fines to fund such projects and activities as receiverships, relocations of residents from substandard homes, survey and inspection activities, Ombudsman Program activities, and special projects for nursing homes for quality improvement, including “culture change.”

B. Resource Center

The D.C. Aging and Disability Resource Center must be fully funded in order to fulfill its mandated duties, including the monitoring of individual providers to insure that correct information about availability, costs, services, and quality of care is being disseminated to the general public. In addition, in order to provide District residents with the choice mandated under federal law to receive long-term care services in their homes and communities, rather than in an institution, the waiver programs must be fully funded and utilized by residents, subsidized housing and subsidies to make homes handicapped-accessible must be made available, and home care and personal care workers must be given the living wage that will keep them from going to Maryland and Virginia for work while District residents languish in institutions for lack of home care services.³¹

C. Casemix System

Since January 2002, the Department of Health has promoted the advantages of a casemix system of Medicaid reimbursement over its current payment system, and since January 2002, DOH has been promising to provide a casemix system. It is time for DOH to deliver what has been promised and to implement and maintain a workable and reliable casemix system that will hopefully both improve care and correct the District's problems of Medicaid overpayments to nursing homes.³² At the same time, the amendments to the final rulemaking for the casemix system (29 DCMR 6500), especially those containing spending ceilings for resident care but not for capitol spending costs, raise the Ombudsman Program's concerns about the ability of the Department of Health to implement a workable system for both the nursing home industry and residents. The Ombudsman program, therefore, recommends that a "pilot program" be implemented to determine whether the proposed casemix system will correct current Medicaid reimbursement overpayments and improve quality of care.

³⁰ The Committee on Health Services, Chaired by David Catania, created a Long-Term Care Task Force that is reviewing this suggestion through its subcommittee.

³¹ Similar recommendations were made by the D.C. Council's task force. *Cf.*, Susan Levine, "Panel Urges Changes in Elderly Care," *The Washington Post*, Dec. 1, 2005, pp. 3 & 9.

³² *Cf.*, "Review of District of Columbia's Accounts Receivable System for Medicaid Provider Overpayments," prepared by the Office of Inspector General, Department of Health and Human Services, August 2005.

D. Training to Address Problems with Care

- As noted above, little progress has been made by the Department of Health on this initiative since it was first articulated in January 2002. Also, as noted above, the Ombudsman Program has serious concerns about the effectiveness of the one step that appears to have been taken by the Department of Health to improve the quality of care in District nursing homes, i.e., restructuring the Delmarva Foundation contract to focus on verification of MDS data. While supporting DOH's stated goal of assisting the nursing home industry to design and implement model training programs for providers and staff, the Ombudsman Program strongly recommends that other steps be taken, as follows, to improve care in the District's nursing homes.

1. Regulatory Changes: Restraints and Staffing

Restraints:

As noted earlier in this report,³³ the current District regulations regarding the use of physical and chemical restraints do not comply with Federal regulations and do not go far enough to eliminate the abuse of physical and chemical restraints. The District's nursing home licensure rules regarding the use of physical and chemical restraints must be amended to follow federal law in order to encourage individualized and restraint free care.

Staffing:

Studies for CMS conducted by experts in the field, as well as studies conducted by the National Citizens Coalition for Nursing Home Reform (NCCNHR) and by other research organizations, show a direct relationship between staffing and quality of care. The study done for CMS, using data from a representative sample of 10 states including over 5,000 facilities, identified nursing assistant and nursing/other licensed professional staffing levels below which facilities were more likely to have quality problems (Centers for Medicare and Medicaid Studies 2002). The minimum levels were 2.8 hours per resident per day for nursing assistants, and 1.3 hours per resident per day for LPNs and RNs.

Nevertheless, the report found that, in 2000: "Over 91% of nursing homes have nurse aide staffing levels that fall below the staffing thresholds identified as minimally necessary to provide the needed care processes for their specific resident population. In addition, over 40% of all nursing homes would need to increase nurse aide staffing by 50 percent or more to reach the

³³ Cf., Note 18.

minimum threshold associated with their resident population, and over 10 percent would need to increase their nurse aide hours in excess of 100 percent....” (Centers for Medicare and Medicaid Studies 2002). More recently, the report on long-term care quality for the National Commission for Quality Long-Term Care, cited earlier, noted that Quality Initiative studies “have repeatedly pointed to the need for additional staffing and other resources in order to sustain quality process enhancements” and that the Institute of Medicine has concluded “that quality of life as a featured outcome will continue to be a fairly low priority in nursing homes until homes are sufficiently staffed to allow for more individualized focus.”

While the District’s 2002 nursing facility rules did provide for a phased-in increase in staffing,³⁴ the Ombudsman Program believes that NCCNHR’s recommended staffing ratio of 4.13 hours of combined nurse and nursing assistance direct care per resident per day is needed to provide care that does more than prevent serious harm to residents. At the same time, the Ombudsman Program recognizes that staffing shortages in nursing homes have many causes, such as low wages, few or no benefits, lack of opportunity for advancement, physically and mentally stressful working conditions, and poor management and training. Increased wages and benefits, the introduction of career ladders, and improved training and supervision would clearly help to recruit and retain nursing home staff, especially nursing assistants.

2. Culture Change

The Ombudsman Program believes that, even if the Department of Health fully implemented its stated initiatives, any increase in the quality of care for residents will not be permanent and substantive unless administrators adopt and implement alternative programs

³⁴ *Cf.*, 22 DCMR 3211.3 Beginning no later than January 1, 2005, each facility shall employ sufficient nursing staff to provide a minimum daily average of 3.5 nursing hours per resident per day. Nursing staff shall be provided in accordance with the following minimum staff-to-resident ratios:

(a) Licensed nurses (RN or LPN) providing planning, coordination, and supervision at the unit level:

Day Shift - 1 FTE for each 35 residents (0.23 hours per resident day)

Evening Shift - 1 FTE for each 45 residents (0.18 hours per resident day)

Night Shift - 1 FTE for each 50 residents (0.16 hours per resident day)

(b) Direct care staff (RN, LPN, or CNA) providing treatment, medications, and other patient care:

Day Shift - 1 FTE for each 5 residents (1.6 hours per resident day)

Evening Shift - 1 FTE for each 10 residents (0.8 hours per resident day)

Night Shift - 1 FTE for each 15 residents (0.53 hours per resident day)

which foster a “culture of change” within each and every nursing facility.³⁵ The ultimate goal of these alternative programs is to move away from the medical model of nursing home care that has dominated the operations and management of nursing homes in the U.S. and to focus instead on the individual physical, social, psychological, and spiritual needs of each resident and on involving the front-line staff in the decision-making process in order to positively affect the daily operation of a home.

The Ombudsman Program is not alone in recommending that the Department of Health provide funding and support to implement “culture change” in the District’s nursing homes. The “Report on Long-Term Care Quality” for the National Commission for Quality Long-Term Care, cited earlier, asserted that these alternative programs “provide tantalizing glimpses of how nursing home culture, operations, and outcomes may be reoriented and seem to imply that some improvement in resident and staff satisfaction can be obtained without increasing costs or sacrificing avoidance of negative outcomes.” The report went on to offer as one of its three major recommendations for improving long-term care quality that a National Demonstration of Nursing Home Culture Change Models be promoted and implemented. In addition, an article on Quality Improvement Organizations, in the August 2004 edition of *Better Jobs Better Care*, by Elise Nakhnikian, Communications Specialist for the Paraprofessional Healthcare Institute, noted that “some within CMS have begun to believe that long-lasting improvements can only come from a wholesale transformation of the nursing culture.”³⁶ The article goes on to quote Marguerite McLaughlin, project coordinator for Quality Partners’ Nursing Home Quality Improvement Initiative,³⁷ as follows:

CMS felt that we’d see a greater success story for each nursing home by improving clinical systems. I think what we’re finding is that if our focus is clinical and all data, we’re not really affecting people. So we proposed that we hook people up with culture change initiatives, getting nursing homes to introduce a more resident-centered model. (p.5)

³⁵ The Methodist Home is the only nursing home in the District to institute an alternative long-term care program. The program, Wellspring, is discussed below in example (c).

³⁶ Page 5.

³⁷ CMS awarded a contract to Quality Partners of Rhode Island to provide technical assistance to Quality Improvement Organizations (QIOs) across the country on the Nursing Home Quality Improvement Initiative because “Most QIOs had little involvement with nursing homes prior to the current scope of work and few had staff with experience in long-term care” (p. 3). DelMarva Foundation is the QIO for the District of Columbia.

The Ombudsman Program recommends that the Department of Health dedicate funds to research, support, and implement the following alternative programs in the District.

(a) The Eden Alternative:

An alternative nursing home approach, Eden uses plants, animals, and children to create an enjoyable and stimulating nursing home environment for residents and staff. This approach focuses caregivers and the culture of the nursing facility on *what is best for the resident*. Another important aspect of the Eden approach is the empowerment of staff by giving them the responsibility and ability to make decisions about matters such as their own work schedules. Research conducted in "Edenized" facilities by Southwest Texas State University has shown a 50% reduction in the incidence of decubitus ulcers; a 60% decrease in difficult behavioral incidents among residents; a 48% decline in staff absenteeism; and an 11% drop in employee accidents.³⁸

(b)The Pioneer Alternative:

The Pioneer approach aims to achieve a change in nursing facility culture by creating a community in which each person matters and makes a difference. The Pioneer Network focuses its efforts on taking a more holistic, individualized approach to nursing home care by working to change governmental policies and regulations that work against providing residents with a maximum of autonomy and independence; change individual and societal attitudes toward aging and elders; change elders' attitudes towards themselves and their aging; and change the attitudes and behavior of caregivers toward those for whom they care. The Pioneer Network refers to this work as a "culture change." Their aim is nothing less than transforming the culture of aging in America, and in nursing homes.³⁹

(c) The Wellspring Alternative:

The Wellspring model is based on the idea that the best decisions about care are made by the staff who are best acquainted with the residents. This approach combines six key elements to improve nursing home quality: developing management committed to making quality of resident

³⁸ Paul R. Willging, American Society on Aging, *The Eden Alternative to Nursing Home Care: More than Just Birds*, available at <http://www.asaging.org/at/at-214/eden.html>.

³⁹ <http://www.pioneernetwork.net/index.cfm/fuseaction/content.display/page/ValuesVisionMission.cfm>

care the first priority; providing training materials and educational courses for staff at the facility; creating “care resource teams” that receive training in a specific area and then teach the other staff; empowering all staff to make decisions affecting the quality of care and the working environment, such as staff schedules; and continually reviewing the facility’s progress in meeting these goals. Good Shepard Services in Wisconsin, one of the eleven homes that implemented the Wellspring approach was able to reduce their nursing staff turnover rate from 105% to 23% over five years.⁴⁰

(d) Growing Strong Roots: Peer Mentoring Program:

As demonstrated by the Growing Strong Roots: Peer Mentoring Program,⁴¹ if the front-line staff is trained and valued for the important role they play in the long-term care facility, then the quality of care for residents can increase. Developed by the Foundation for Long-Term Care (FLTC), this program combines peer mentoring for Certified Nursing Assistants (CNAs) and trainings for nursing home management with a focus on helping CNAs becomes an integrated part of the facility, thus increasing satisfaction and retention of CNAs and improving the care provided to residents. *Growing Strong Roots* emphasizes the critical role of the nurse’s aid to the functioning of the nursing facility and values the experienced employee as he or she mentors the newcomer. This plan, evaluated in eleven nursing homes, result in CNA retention rates increasing by 25%. Through this project, a nursing home can initiate and maintain improvements in their daily operations by creating a “culture of care” within the facility.

IV. CONCLUSION

The federal and District nursing home laws set minimum quality of care standards for the nursing home industry. It appears, however, that some D.C. nursing homes fail to meet even these minimum standards while others deliver only the minimum care and services to nursing home residents – care and services directed simply to avoiding serious mistakes that would cause actual harm to residents but that ignore questions about the quality or care and quality of life that residents are experiencing. When nursing homes fail to meet federal and local standards and

⁴⁰ Robyn I. Stone, Commonwealth, *Evaluation of the Wellspring Model for Improving Nursing Home Quality*, August 2002

⁴¹ Carol R. Hegeman, M.S., *Peer Mentoring of Nursing Homes CNA’s : A way to Create a Culture of Caring*,(2003).

blatantly violate the law, it is the duty of the surveyors and inspectors to enforce the law and ensure that violations are resolved and not repeated. The Ombudsman Program finds that this is one area where the District of Columbia fails the resident, by not doing enough to protect residents' rights, impose appropriate monetary penalties, and monitor and enforce plans of correction.

After evaluating approximately four and half years worth of survey reports, complaint data, DOH Quality Initiatives Plans, and studies by government and independent research organizations, the Ombudsman Program continues to have significant concerns about the health, safety, and welfare of the District's nursing home residents. The Ombudsman Program hopes, therefore, that this serves not only as a reflection of the current progress made by the DC Department of Health in improving the quality of care in the District's nursing homes, but also as a managerial tool for both the nursing home industry and D.C. Government officials willing to work on improving the quality of care and life for nursing home residents.⁴²

V. CONTACT INFORMATION

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⁴² This report concludes the Ombudsman Program's "Broken Promises" project.

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