LTCCC
LONG TERM CARE COMMUNITY COALITION

MONITOR

Working to improve long term care through research, education & advocacy

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Can the Law Protect Nursing Home Residents?

The crisis in the nursing home system is well known. Throughout New York State and across the country, there is widespread suffering and even premature deaths resulting from poor nursing home care. According to a recent government report, 98% of New York nursing homes don't even meet the minimum staffing levels necessary to give basic care to residents!

As a result of insufficient staffing and other systemic problems, nursing home residents are harmed. When there is insufficient time to take residents to the bathroom, they are forced to wear diapers unnecessarily or, even worse, frequently wind up sitting for hours in their own waste. When there is not enough time to properly feed residents, they often go hungry. Remarkably, malnutrition and dehydration are leading causes of illness and death among nursing home residents, an especially striking statistic given that this tragedy is occurring in the 21st century, in the world's wealthiest country, in New York State.

"LTCCC's report... can be used to find out about residents' rights and protections..."

LTCCC REPORT: Everyone has heard how terrible nursing homes can be. Unfortunately, too many of us believe that 'that's just how things are' or

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In This Issue...

NYS To Enact Harsh Medicaid Rules

After intense negotiations, the Governor's Budget Bill for 2006-2007 was finally passed. Fortunately, the final outcome as related to Medicaid eligibility was not as bad as initially anticipated. Governor Pataki's attempt to limit home care eligibility by penalizing transfers of assets and eliminating spousal refusals for both home care and nursing home care did not become law. The current home care rules remain intact and spousal refusal is still available.

Spousal refusal allows a community spouse with assets in excess of the community spouse resource allowance ("CSRA" – currently a maximum of $95,100) to refuse to contribute to his/her institutionalized spouse's care. If a community spouse with resources above the CSRA executes a spousal refusal, the institutionalized spouse with resources below the allowable resource level (currently $4,150) must be found Medicaid eligible. The caveat is that the Medicaid agency has the right to recover from the community spouse for benefits paid on behalf of the sick spouse. The Medicaid rate for nursing home care, however, is typically about 30% less than the private rate. Hence, the community spouse would be repaying Medicaid a lesser amount than if he or she privately paid the nursing home.

The budget bill incorporates relevant Medicaid eligibility provisions found in the federal Deficit Reduction Act ("DRA"), which was signed by President Bush on February 8, 2006. The DRA includes rules regarding look back periods, periods of ineligibility, equity interests in the home, and the purchase of life estates, among others.

The look-back period for Medicaid nursing home applications was extended from three years to five years for all assets transferred after February 8, 2006. This extension will gradually be phased in over time. As an illustration, for a Medicaid application filed on

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that nothing can be done to make things better – bad treatment is "to be expected." In fact, the federal Nursing Home Reform Law, which was passed almost 20 years ago, changed those expectations significantly. Last year, LTCCC embarked on a year-long national study, with funding from the Robert Sterling Clark Foundation, to investigate what happened to that law and what was being done to make its promise a reality. The goal of our study was to identify the central protections available to nursing home residents and give stakeholders – residents, family members, long term care ombudsman – as well as government leaders information and insights in to how they can help achieve the promise of the law.

THE LAW: The Nursing Home Reform Law, commonly referred to as OBRA 87 (it was part of the Omnibus Reconciliation Act of 1987), established strong legal mandates for nursing homes. Under OBRA 87:

• "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being…"

• Nursing homes are required to ensure that 'a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to… (i) Bathe, dress, and groom; (ii) Transfer and ambulate; (iii) Toilet; (iv) Eat; and (v) Use speech, language, or other functional communication systems.'

• Nursing homes are responsible for ensuring that every resident receives 'appropriate treatment and services to maintain or improve his or her abilities specified [above].'

• Any resident unable to carry out activities of daily living must receive 'the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.'

Nursing homes which are not providing these services and protections are in violation of federal law. And state oversight offices which are not making sure that the law is fully enforced are not doing their job. But what can a resident, family member or friend do?

IDEAS FOR ACTION: LTCCC's report - available at www.nursinghome411.org – contains details and resources on legal protections for nursing home residents. The report provides information on actions and innovative activities taken across the country to overcome challenges to enforcing those legal protections. The report is divided up into specific sections identifying legal cases that residents can make when the system has failed to protect them, specific state activities and state law provisions, ombudsman activities that have overcome systemic obstacles to ombudsman advocacy and interviews with individuals who have been innovative in tackling nursing home quality and accountability problems. For the consumer, this report can be used to find out about residents' rights and protections, and what they can do to initiate change (both personally and in their community).

A sampling of ideas & activities:

• Deborah Truhowsky, an attorney in private practice in New York, was selected to be interviewed because she is using a section of the NY State Public Health Law as a basis for holding nursing homes accountable. This law creates a private right of action for nursing home abuse; it provides that any residential health care facility that injures a resident by virtue

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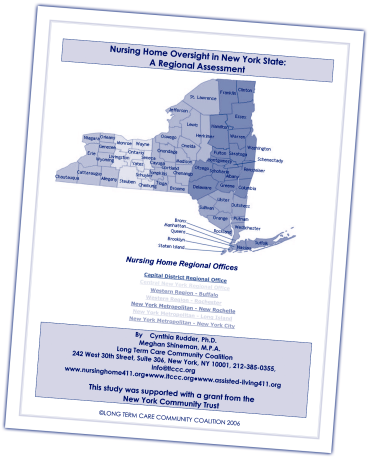
New LTCCC Report Investigates Nursing Home Inspection and Surveillance Systems

The vulnerable residents in New York State's (NYS) nursing homes depend on the state to hold nursing home providers accountable for the care they receive. This is accomplished by identifying problems that need correction during regular state inspections and through investigations of consumer complaints by the Department of Health (DOH).

Because these state oversight mechanisms are crucial to ensuring resident safety, the ability of surveyors to accurately identify and cite problems in a nursing home is essential. Each deficiency, once identified, is rated for severity and scope. Severity relates to the level of harm (real or potential) to the residents and scope relates to the number of residents potentially or actually affected. The accuracy of the determination of scope and severity is very important as it determines how quickly a problem needs to be corrected, the type of penalty that might be imposed and how serious the citation will be viewed by the facility.

In 2005, LTCCC issued a report on NYS's ability to protect nursing home residents through its inspection and surveillance program. The comparison of NYS to other states and to federal oversight mechanisms indicated that New York is lagging in its ability to protect nursing home residents.



We have now released a new study, conducted as a follow-up to our 2005 study, to focus specifically on the effectiveness of NYS's inspection and complaint systems by comparing the seven different nursing home regional offices in NYS to each other, in terms of deficiency writing and complaint substantiation. Our goals were to identify specific issues in areas across the state, assess each region's strengths and weaknesses and develop recommendations for improving oversight specific to the issues faced in each region. In addition, the use of fines was examined.

Findings

Identification of care problems is a problem in all of the regions. All regions were found to be below the national average of deficiencies per facility. New York City's performance was the worst in the state. The Central regional office was the best.

Complaint substantiation rates were low across the regions. Less than six percent of all complaints are substantiated (e.g., a statement of deficiencies was written related to the complaint). Buffalo had the highest substantiation rate and New Rochelle has the lowest substantiation rate in the state.

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of violating any federal statute or code shall be liable to that resident in damages. Ms. Truhowsky spurns the idea that injuries such as bruises, falling and bedsores are unavoidable consequences of growing older or unavoidable conditions in long term care facilities. Ms. Truhowsky is unique because more common grounds for suing a nursing home include: negligence, wrongful death, intentional tort, negligent hiring and supervision and breach of statutory/regulatory rights, duties or responsibilities.

• Massachusetts's attorney general's office has an Elder Abuse Project. This project seeks to improve the capacity of law enforcement, including police, prosecutors, victim-witness advocates, probation officers, and elder services professionals to more effectively recognize, investigate and prosecute a wide range of abuse perpetrated against older individuals.

• The DC Ombudsman filed a lawsuit to implement a model transfer and discharge plan.

• The New Mexico Ombudsman went undercover in nursing homes – which led to new state law to permit this type of activity.

• Washington State's Long Term Care Ombudsman Program was instrumental in promulgating legislation that makes mistreatment of the elderly a criminal offense. Washington's Ombudsman Program also has access to an attorney and is able to use him as a resource to strengthen their advocacy efforts.

All materials can be downloaded for free at www.nursinghome411.org ❑

NYS To Enact Harsh Medicaid Rules

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February 8, 2010, four years of documentation (going back to February 8, 2006) should be required. It will not be until February 8, 2011 that a full five years of documentation will be required.

One of the most significant changes relates to the period of ineligibility created by transfers of assets for less than fair market value, i.e., gifts. Prior to enactment of the legislation, if a Medicaid applicant gifted assets within the 36 months prior to submission of a nursing home application, the period of ineligibility began on the first day of the month after the gift was made. Under the new law, for applications submitted after August 1, 2006, if an applicant gifts assets after February 8, 2006, the period of ineligibility for Medicaid nursing home benefits will begin only when the individual is in a nursing home and is "otherwise eligible" for Medicaid, i.e. he or she has assets under the resource allowance, currently $4,150. Hence, if an individual gifts assets on September 1, 2006, but enters a nursing home and applies for Medicaid on March 1, 2008, the period of ineligibility will begin March 1, 2008 (instead of October 1, 2006 under the old law).

Under prior law, if an individual applying for Medicaid had equity in a home of any value, the individual could qualify for Medicaid nursing home benefits by expressing an intention to return to the home. Medicaid could subsequently place a lien on the home, which would be repaid upon the sale of the home or death of the individual. The DRA mandates that individuals with home equity exceeding $500,000 (except where a spouse, minor or disabled child resides in the home) are ineligible for Medicaid benefits. However, New York raised the threshold to $750,000, as allowed by the DRA.

Some good news is that the DRA affirms that Medicaid will not penalize an applicant for the purchase of a life estate in another individual's home, as long as the applicant lives in the home for at least one year after the purchase. A life estate is the right to possession, use and occupancy of a premises during one's lifetime and is reflected on the deed. Therefore, a senior may purchase life use of an adult child's home (the value of which is determined using federal charts) and if the senior lives in the home for one year subsequent to the purchase, the transaction will not affect the individual's future Medicaid eligibility.

On another positive note, the exemptions for transfers to a spouse, disabled or minor child remain. Also intact are the exemptions for the transfer of a home to a caretaker child residing in the home for two years prior to institutionalization or to a sibling with an equity interest who has been residing in the home for at least one year prior to institutionalization.

The recently released General Information System Division release ("GIS") from the Office of Medicaid Management reflects the enactment of the Governor's Budget Bill. The most important information in the GIS is that eligibility changes, initially anticipated to be implemented on July 1, 2006, are now being implemented on August 1, 2006. Hence, the new rules will not apply to Medicaid applications submitted prior to August 1, 2006.

Further, the GIS reiterates that New York will not expand the definition of "estate" (to include non-probate assets). In other words, if an asset passes from a Medicaid recipient directly to a beneficiary, Medicaid may not recover for payments that it made on the recipient's behalf. Finally, the legislation affects the use of annuities in Medicaid planning.

The type of annuity used in Medicaid planning is an investment vehicle whereby an individual purchases the right to a stream of income for an actuarily sound term of years i.e, a term not to exceed the individual's life expectancy. In order to be considered unavailable, the annuity must be irrevocable, non-assignable and have no cash surrender value. Pre-DRA annuities were purchased by some community spouses to reduce excess resources to avoid recovery by Medicaid and by some applicants who needed short term institutional care and desired a stream of income after discharge from a nursing home. The owner was able to name a beneficiary of his or her choice to continue receiving the stream of income after his/her death, for the remainder of the term. The GIS indicates that if an applicant or the applicant's spouse purchased an annuity after February 8, 2006, the State must be named the beneficiary.

This article was written by Ronald A. Fatoullah, Esq. and Stacey Meshnick, Esq. Mr. Fatoullah is the principal of Ronald Fatoullah & Associates, an elder law and estate planning law firm with offices located in Great Neck, Forest Hills and Brooklyn, New York. Ms. Meshnick is a senior staff attorney at the firm and supervises its Medicaid department. The authors can be contacted at 1-877-ELDER-LAW. ❑

Update on Assisted Living

Thanks to all of you who went to our Website's citizen action center and sent emails, letters and faxes on the need for RNs in the enhanced level of assisted living. Nine hundred twenty messages were sent. The Department of Health and the State Office on Aging now agree that RNs are needed. In fact, DOH and SOFA staff have mentioned the many letters they have received from consumers across the state on this issue! As of this writing, DOH and SOFA have taken the position that residences with enhanced and special needs certification must have:

- RNs for one shift a day, five days a week,
- LPNs for one shift a day, five days a week,
- LPNs two shifts a day on the weekends, and
- Aides, with additional training, on the night shift.

That's the good news. The bad news is that many providers will continue to fight this mandate once the proposed regulations are published for comment. Although the Empire State provider association's lawsuit, suing the state for proposing strict regulations that they believe is contradictory to the assisted living law, has been taken off the court calendar, it can be reinstated at any time. Thus, it will be crucial for concerned citizens to keep up the fight. Consider joining our action alert list if you have not already done so by sending an email to info@ltccc.org with the message "please subscribe me for action alerts" or check our assisted living website regularly (www.assisted-living411.org) for the latest action alerts.

Amending the Assisted Living Law

Although the passage of the assisted living law was a major victory for seniors and disabled people in New York, there are a few ambiguities in the law that could be interpreted in a way harmful to consumers and, we believe, against the very philosophy of the law and of assisted living. We would like the legislature to examine them and, if necessary, amend the law to protect consumers.

For residences that want to be certified to provide enhanced assisted living, meaning that people can stay as they grow more frail and have greater needs, the law does not mention how many "slots" they have to have for providing enhanced services.

Problem: Consumers who enter an assisted living residence certified to give enhanced services may not be able to remain if they grow more dependent because there may not be any enhanced "slots" available when they need them.

Example: Mary moves into an assisted living residence with enhanced certification, because she believes she will be allowed to stay in her new home if she becomes more frail. Two years later, Mary has a minor stroke. She recovers, but needs more assistance with daily living. The community only applied for enhanced certification for two slots, and both are being used. Mary has to leave. Her only option might be a nursing home, which is what she always wanted to avoid.

LTCCC Recommendation: A minimum percentage of the community must be certified for enhanced care in order for certification to be approved. All marketing and communications referring to enhanced must make clear the number of enhanced slots available.

The law does not specify what services must be provided by a provider of enhanced assisted living services. Thus, providers are saying that they can pick from among different services rather than requiring that all reasonably anticipated needs be provided for.

Problem: Consumers, believing they can age-in if they go to an assisted living with enhanced certification, may find that the service they need, such as help with medical equipment, is not offered and they will have to leave.

Example: Sid moves to an enhanced assisted living so that he can stay in his new home if he should come to require additional services. A few months later, Sid loses his balance and falls. Luckily, he is able to make almost a full recovery, except that from now on he

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Enforcement Actions Against Nursing Homes[1]

Civil Money Penalties[2] Against Nursing Homes: 3/16/06 – 5/31/06

NAME OF HOME	LOCATION	SURVEY DATE	AMOUNT
Dumont Masonic Home	New Rochelle	10/25/05	$2,275.00
Eden Park Health Care Centre	Cobleskill	3/3/06	$43,622.50
Fairport Baptist Homes	Fairport	3/30/06	$2,632.50
New Carlton Rehabilitation and Nursing Center	Brooklyn	9/6/05	$47,775.00
Peninsula Center for Extended Care and Rehabilitation	Queens	12/28/05	$34,450.00
Riverview Manor Health Care Center, LLC	Owego	11/21/05	$104,500.00
Sheridan Manor Nursing Home	Tonawanda	12/9/05	$1,000.00
Split Rock Rehabilitation and Health Care Center	Bronx	12/5/05	$112,320.00
Terence Cardinal Cooke Health Care Center	New York	8/29/05	$33,897.50
Wedgewood Nursing Home	Spencerport	12/8/05	$2,275.00
Workmen's Circle Multicare Center	Bronx	10/11/05	$69,550.00
Wyoming County Community Hospital SNF	Warsaw	3/3/06	$975.00

[1] These lists will be posted on LTCCCs website every three months.

[2] As reported by Centers for Medicare and Medicaid Services (CMS). For more detailed information contact the FOIA Officer at CMS 212-616-2345.

Now Available!

Free guides for people in nursing homes dealing with Medicare Part D prescription drug plans.

Go to www.nursinghome411.org to get your free guide!

Enforcement Actions Against Nursing Homes

STATE FINES AGAINST NURSING HOMES: 3/16/06 – 6/15/06[1]

NAME OF HOME	LOCATION	DATE OF SURVEY	AMOUNT[2]
Amsterdam Memorial Hospital SNF	Amsterdam	6/5/03, 10/28/03	$3,000
The Center for Nursing and Rehab at Birchwood	Huntington Station	7/2/03, 5/27/04	$5,000
Far Rockaway Nursing Home	Queens	1/11/05	$4,000
Highland Care Center, Inc.	Queens	3/3/03, 1/9/04	$15,000
Riverhead Nursing Home	Riverhead	9/16/04	$2,000
Williamsville Suburban Nursing Home	Williamsville	6/16/05	$1,000
Willow Point Nursing Home	Vestal	2/20/04, 1/28/05	$1,500

In addition to the actions listed below, the following nursing homes are also subject to a fine. If the nursing home was found, at the time of the survey, to have given substandard quality of care (SQC) and/or to have put residents in immediate jeopardy (IJ), the most serious level of deficiencies, or to have repeated deficiencies that have caused isolated resident harm (G) it is noted in the third column. Double G means the home has received Gs in two consecutive surveys. IJ Removed means the facility was identified to have immediate jeopardy during the survey but removed the situation that caused Immediate Jeopardy prior to the end of the survey.

The State Took Other Action Against 13 Nursing Homes 3/16/06 - 6/15/06[1]

NAME OF HOME	LOCATION	IJ,SQC or G	SURVEY DATE	ACTIONS[3]
Albany County Nursing Home	Albany	IJ, SQC	5/8/06	State Monitor, POC, Inservice, DOPNA
Eger Health Care Center	Staten Island	IJ, SQC	4/7/06	State Monitor, Inservice
Fairport Baptist Homes	Fairport	IJ removed	3/30/06	POC, Inservice, DOPNA
Hebrew Home: Riverdale Palisade Avenue	Bronx	IJ removed, SQC	3/16/06	State Monitor, POC, DOPNA
The Hurlbut	Rochester	IJ, SQC	4/14/06	State Monitor, POC,
Marcus Garvey NH	Brooklyn	IJ, SQC	5/18/06	State Monitor, POC, Inservice, DOPNA
Providence Rest	Bronx	GG	4/24/06	POC, Inservice, DOPNA
Riverview Manor NH	Owego	IJ, SQC	4/12/06	State Monitor, POC, Inservice, DOPNA
The Shore Winds	Rochester	IJ removed	3/10/06	State Monitor, POC,
Vivian Teal Howard RHCF	Syracuse	GG	3/16/06	POC, Inservice, DOPNA
The Waters of Aurora Park	East Aurora	IJ	3/10/06	State Monitor, POC, Inservice, DOPNA
Williamsville Suburban Nursing Home	Williamsville	IJ removed, SQC	4/6/06	State Monitor, POC, Inservice, DOPNA
Willow Point Nursing Home	Vestal	IJ, SQC	3/6/06	State Monitor, POC, Inservice, DOPNA

[1] As reported by the Department of Health (DOH). For more detailed information call the DOH FOIL Officer at 518-474-8734 or e-mail – nhinfo@health.state.ny.us.

[2] Under state law nursing homes can be fined up to $2,000 per deficiency.

[3] Denial of Payments for New Admissions (DoPNA): Facility will not be paid for any new Medicaid or Medicare residents until correction; Directed Plan Of Correction (POC): A plan that is developed by the State or the Federal regional office to require a facility to take action within specified timeframes. In New York State the facility is directed to analyze the reasons for the deficiencies and identify steps to correct the problems and ways to measure whether its efforts are successful; In-Service Training: State directs in-service training for staff; the facility needs to go outside for help; State Monitoring: state sends in a monitor to oversee correction; Termination means the facility can no longer receive reimbursement for Medicaid and Medicare residents.

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will need assistance with walking up and down stairs. The residence administration tells him this is not one of the services they provide and that he will have to move.

LTCCC Recommendation: Certification must require the provision of all five services listed in the present law.

The law says nothing about what happens when a resident in an enhanced assisted living needs those enhanced services.

Problem: People who come to need enhanced services may discover that their residence only provides those services in special sections.

Example: Angela moves into an enhanced residence and after making herself at home for three years comes to need enhanced services. The resident manager tells her she will need to move to another area of the residence, packing up her things and leaving behind her neighbors and her roommate, who she had worked hard to get along with.

LTCCC Recommendation: Residents must have the right to remain in place – in their own room or apartment. The enhanced services should come to them whenever possible.

The law only requires a uniform assessment for pre-admissions.

LTCCC Recommendation: Uniform assessments must be required for all on-going assessments. This will permit the Department of Health, which will be inspecting residences for compliance with regulations, to be able to easily check if residences are properly evaluating resident status.

Future Issues

The State Task Force is beginning to consider two major issues of interest to consumers: (1) medication administration and assistance and (2) how to make assisted living affordable. Some providers on the Task Force seem to believe that trained aides should be permitted to give medication assistance to consumers who are not self-directing. It is our position that this is not assistance; this is administration and only licensed nurses can administer medication to individuals who are not self-directing - individuals who do not have the capability to make choices about activities of daily living and who do not understand the impact of these choices and cannot assume responsibility for the results of these choices. A trained aide can assist residents who are self-directing (intellectually) but who need assistance such as opening a container, timely reminders, etc.

The issue of training for people giving medication assistance will also be taken up at the Task Force. Cynthia Rudder, LTCCC's director of special projects and a member of the Task Force, is on the medication subcommittee.

The Task Force has also begun to discuss ways to make assisted living affordable to middle and low income people. While It is crucial to make the assisted living concept affordable to all New Yorkers as quickly as possible, we believe that before any proposals to add additional public funding can even be considered, the state must first decide upon the "model" of assisted living (housing components as well as services) that should be affordable and accessible to all.

For New York to simply provide increased funding for existing adult homes, enriched housing or assisted living programs would be a tremendous disservice to the very people that are meant to benefit from an affordable assisted living policy. For example, many homes that primarily serve the elderly or disabled impede their continued involvement with the outside community because of their location and/or lack of available transportation services. Some do not even have safe outside areas for their residents to go to. Similarly, adult homes were never designed and do not currently have the appropriate services for people with psychiatric disabilities. Many adult homes serving people with psychiatric disabilities are large and isolated institution-like settings which offer little or no rehabilitative treatment to promote integration into the community. Thus, simply increasing funding to these facilities will do nothing to change the quality and nature of these homes or the quality of life for those people who live in them.

We believe that it is crucial for the Task Force to first help develop a model that NYS should make affordable. Any proposal to add public funding should include a number of different criteria in addition to licensure such as:

• Provide people with a wide range of choices about where they can live and receive services, including their own homes/apartments.

• Provide people with private rooms, private baths and resident accessible kitchens and self-directed care and programs.

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Assessments Should Be Required *Prior* to Wheelchair Placements

Presently wheelchairs are mostly used for any older person who is at risk for falls. Once a person is placed into a wheelchair, often within three weeks of continual use they will never walk unassisted again due to general muscle atrophy. Extended wheelchair use as a seating device causes a diminishment in the following conditions: physical, mental and psychosocial rehabilitation potential; muscle condition; appetite; ability to perform ADLs; restful sleep; physical exercise; and ability to stand, pivot and walk. Wheelchair use often causes an increase in infections; withdrawal in social contacts; greater likelihood of incontinence and fecal impaction; depression and weight loss (among other problems). These are all often completely unnecessary occurrences when simple exercise and muscle strengthening will enable most people to continue walking and leading healthier lives.

The Long Term Care Survey, October 2005 Edition, Guidance to Surveyors are the federal regulations that regulate long term care facilities. It was brought to our attention that in 2005 one of these regulations, called F309 was cited in more than 31% of facilities who received this tag in 2005, according to Jeane Nitsch of CMS. She stated: "In actuality F309 (42 C.F. R. 483.25) was cited more times that any other tag in calendar year 2005. Thirty-one percent of facilities received a deficiency citation at this tag in 2005." Under F 309 each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The federal regulations are the minimum standards that must be followed and almost one third of the facilities are not even meeting the minimum standards on this regulation.

Wheelchairs are known to be used by staff for staff convenience. The staff of facilities seem to find it

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• Comply with the Americans with Disabilities Act mandates that people with disabilities, including Alzheimer's Disease, should receive services, programs, and activities in the least restrictive, most integrated setting appropriate to their needs.

• Ensure access to appropriate medical and personal care.

• Provide qualified, trained and appropriately supervised staff receiving a living wage.

• Provide opportunities for activities and recreation in the home and the community.

• Provide availability and access to transportation.

• Provide meals that are appropriate to each individual's dietary needs.

For more specifics on this issue visit www.assisted-living411.org and read our brief on affordable assisted living. A number of organizations have signed on in support of this brief. If your organization would like to join please contact our office.

1. Go to the Long Term Care Action Alert Center on our Website (www.ltccc.org) and click on the messages relating to assisted living.

2. Send an email, letter or fax to policy makers on the following issues. Simply click on to send the sample message or write one of your own:

a. Thank the Department of Health and Office on Aging for its position on RNs in assisted living.

b. Urge them to support our position on affordable assisted living. Use the points made above.

c. Urge legislators to amend the assisted living law to include the points we have made above. ❑

New LTCCC Report...

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All of the regions' deficiency ratings of harm were below national averages. Most of the state deficiencies cited were rated as having only the potential to cause harm. However, compared to the other regions, the Capital region stands out by writing the most deficiencies at the actual harm level. On the other hand, New Rochelle wrote no deficiencies at this level and almost no deficiencies at the immediate jeopardy level. The New York City region wrote the most deficiencies at the immediate jeopardy level.

Except in the Capital region, most of the deficiencies cited in NYS were rated as isolated - affecting only a few residents. The Capital region rated over half of its deficiencies as being a pattern. New Rochelle, Long Island and New York City had the highest ratings of widespread in the state.

Over one-third of all facilities are fined in the state. However, New York City lags behind the rest of the state in this area. It fined the fewest number of its facilities. The Rochester region fined the largest percentage of its facilities, fining over half since 2002. Nevertheless, on the whole, New York State's average fine is below national averages.

Reasons for Differences

The study looked at many variables to discover why some regions were better than others. We found that confusion about how to define actual harm and immediate jeopardy and experience and use of contract workers seemed to make a difference in surveyor performance. Confusion was indicated by the finding that similar deficiencies were rated differently by surveyors in different regions and/or in the same region. In addition, those regions with more state employees and less contract staff, and those with more experienced workers (working three years or more), were found to identify more problems and write the most deficiencies.

There were a number of variables that we looked at that surprisingly did not relate to identifying problems: timing of surveys, staffing levels in the nursing homes being monitored and use of resident and family interviews. If surveyors inspect nursing homes at the same, or almost the same time each year, the survey can lose its surprise element. The study found that a number of regions have been trying to change the timing of their surveys, moving from annual surveys within 45 days of each other to earlier than or later than 45 days. However, we did not find that this change in timing led to better identification of problems. It might be that the pattern must be changed to inspecting earlier rather than later than the 45 day time frame in order to keep the surprise element. Many studies have shown the connection between quality of care and numbers of nursing staff. Thus, we expected that regions where facilities had the lowest levels of nursing staff would cite the most deficiencies and would rate them high in severity and scope. However, our findings do not demonstrate this.

And, we expected to find that those regions citing high severity ratings would be the ones that interviewed residents and families/significant others the most. However, this is not the case. The lack of effect may be a result of the generally low uses of both resident and family/significant other interviews statewide. Only 18.5% of the cited NYS deficiencies used residents to help document the findings and only 1.6% of all deficiencies cited in NYS used families/significant others to help document the citation.

For Example…

A sulfa drug was repeatedly administered to a resident with a known allergy to sulfa containing drugs. The resident was documented as being in pain (headache), swelling of the face, eyes, lips and both legs, shortness of breath which required a breathing treatment, increased agitation, difficulty breathing, unresponsiveness and foaming at the mouth. The negative effects on the resident lasted for four days and the resident was transferred to the hospital with hypoxia, congestive heart failure and probable pneumonia. ***Citation was rated as causing no harm.***

A facility was cited for not ensuring appropriate treatment to correct an assessed mental or psychological problem. A resident was agitated, verbally and physically abusive toward staff, refused medications, meals and activities and the facility did not deal with these behaviors. ***Citation was rated as causing no harm.***

Conclusion

The fact that all regions had areas of strength, or comparable strength, and weaknesses may indicate

that DOH concentrates its surveyor training on one identified weak area. Although the reason for this may be because of limited resources, this seems to be a "crisis mode" way of responding by "triaging" the problems and may not be an effective method. By working on only the most egregious problems at any one time may mean DOH misses a chance to improve the entire nursing home survey and certification process, and ultimately the quality of care nursing home residents are receiving.

Recommendations to the Department of Health:

1. Evaluate surveyor turnover by hiring an independent consultant to evaluate either why it is so difficult to hire surveyors and/or why surveyors leave before getting enough experience to be effective in those regions where the data indicate problems.
2. Analyze the strengths and weaknesses in each region and introduce findings into surveyor training.
3. Evaluate effectiveness of surveyor training by conducting pre- and post-testing of the effectiveness of the surveyor training that evaluate whether the training changed actual surveyor outcomes, not merely if the surveyors understood the training.
4. Increase the use of resident and family/significant other interviews to document citations by requiring all surveyors to document such interviews for each care related deficiency cited. Require all surveyors to telephone a family member/significant other for an interview for all residents determined to be ineligible for interviewing.
5. Develop a process to prevent repeat deficiencies by mandating that all successful plans of corrections be in place until the following survey or until DOH determines that the plan is no longer needed by going onsite. In addition, DOH should mandate that if a facility wants to change the plan of correction, it must get approval from DOH and DOH must monitor any changes to plans of corrections.

To read both full reports, go to our Website, www.nursinghome411.org. ❑

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Assessments Should Be...

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easier to care for someone once they have been placed into a wheelchair. According to Guidelines to Surveyors, "convenience" is defined as any action taken by the facility to control a resident's behavior or manage a resident's behavior with a less amount of effort by the facility and not in the resident's best interest."

According to the MDS Active Resident Information (under B2A) reports dated 4th Quarter 2005, 73% of residents living in long term care facilities today are cognitively impaired. Placing a resident with a cognitive loss into a wheelchair for purposes of regular seating or transportation when the person could ambulate, leads to negative physical, mental and psychosocial well-being. Due to the resident's cognitive loss they often cannot express their desire to sit in a regular chair or to ambulate rather than be transported yet their body continues to tell them to get up and walk, which they try to do. Those with weakened muscles tend to fall. This can result in chair alarms being placed on them to control their walking, exacerbating the problem of muscle atrophy.

A grass roots group, called GROW Coalition (Getting Residents Out of Wheelchairs) has been formed to meet with people at CMS to get this long overdue oversight changed. The GROW Coalition is proposing the following solutions: CMS should consider re-examining the federal regulations with a greater focus on determining how the assessment of need for a wheelchair should be placed into the Guidelines to Surveyors and require that each person be assessed for conditions to make sure that they absolutely require wheelchair use. Wheelchairs should also be considered a form of restraint if the individual does not require the aid of a wheelchair.

We believe that positive outcomes will be realized, such as major improvements in quality of care as well as large decreases in expenditures in Medicare and Medicaid expenses. Requiring assessment prior to wheelchair use will also create a more homelike, personal, non-wheelchair focused environment, and center rehabilitation on maintaining normalcy for the individual in their seating and ambulation. These changes will provide a look and feel that the people residing in long term care are valued as individuals.

This article was written by Mary M. Harroun and Diana Waugh, Co-Founders, GROW Coalition. They can be contacted at growcoalition@comcast.net. ❑

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