

LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

Improving Nursing Home Resident Safety, Dignity, & Financial Integrity: Recommendations for CMS

Table of Contents

ADDRESS PERVASIVE AND LONGSTANDING INADEQUATE STAFFING	2
IMPROVE ENFORCEMENT OF MINIMUM STANDARDS OF CARE.....	3
IMPROVE TRANSPARENCY ON NURSING HOME QUALITY AND SAFETY	5
IMPROVE OWNERSHIP AND FINANCIAL ACCOUNTABILITY	6
CORRECT OTHER OPERATIONAL BIASES TOWARD FACILITIES	7
IMPROVE THE USE OF CMP FUNDS BY THE STATE & CMS	8

ABOUT THE LONG TERM CARE COMMUNITY COALITION

The Long Term Care Community Coalition (LTCCC) is a non-profit, non-partisan organization dedicated to improving care in nursing homes and other residential care settings. Please visit our website, www.NursingHome411.org, for information on nursing home quality, staffing and safety, as well as a range of resources, including:

- The Dementia Care Advocacy Toolkit
- Fact Sheets on Residents' Rights and Care Standards
- Staffing & Quality Data (for all licensed U.S. nursing homes)
- The *Elder Justice Newsletter*
- Reports & Alerts on Important LTC Issues
- Informative Webinars & Podcasts

Address Pervasive and Longstanding Inadequate Staffing

Failure to require minimum staffing levels has been shown to result in poor care and harm to residents. It is contrary to the fundamental purpose of the 1987 Nursing Home Reform Law to permit nursing homes to accept and/or retain residents for whom they do not have sufficient care staff.

Recommendations:

1. Immediately adopt numerical minimum staffing standards to meet the requirement for “sufficient” staffing in place since passage of the Nursing Home Reform Law of 1987. The minimum standard should be 0.75 RN hours per resident day (hprd), 0.55 LVN/LPN hprd, and 2.8 CNA hprd, for a total of at least 4.1 nursing hprd to meet the federal requirements.
2. Require all nursing homes to provide RN staffing on a 24-hour day basis.
3. Eliminate all federal and state waivers of minimum staffing levels.
4. Conduct a new nursing home staffing time study. The study should determine the time needed for RNs, LPNs, and CNAs to complete all the various tasks needed to assess, plan, manage, supervise, and provide resident care for residents with different acuity levels. The study should identify the discrete nursing tasks and time for different levels of acuity and should simulate how much time is needed to provide care to meet regulatory requirements based on acuity. It should include all nurse administrative and supervision time for both non-resident and resident care activities (direct and indirect time). The study should be carried out by CMS or a research organization with expertise and experience in conducting such staffing studies.
5. Effectively enforce existing staffing standards, which require facilities to have sufficient staff to meet the care, social, and dignity needs of the residents they admit. Research shows that staffing is the most important indicator of a facility’s quality and safety. Nevertheless, insufficient staffing is universally recognized to be a widespread problem. To improve enforcement of minimum staffing standards, CMS should:
 - Revise vague guidelines on staffing enforcement that classify staffing violations as either “potential harm,” “actual harm,” or “immediate jeopardy,” with automatic increases for repeated staffing deficiencies.
 - Clarify that, while surveyors do not need to directly observe staffing violations themselves, they are expected to investigate resident care records; review resident, family, and ombudsmen documentation; and conduct interviews as evidence.
 - Issue pre-established penalties for violations, with a denial of payment for new admissions until staffing levels are deemed to meet federal requirements; use a temporary manager, when necessary, to achieve compliance.
 - Establish a unit to audit PBJ staffing data accuracy (needed to address increasing reports of fraudulent staffing reporting) with penalties for nursing homes with fraudulent reports. The unit should be charged with alerting state survey agencies of nursing homes with low staffing and staffing levels that do not meet

- minimum federal standards. Establish protocols to ensure that state agencies investigate and implement appropriate enforcement actions in response to reports of low staffing.
- Establish automatic fines for facilities that fail to meet the minimum federal staffing requirements based on PBJ data reports.
 - Require nursing homes to provide adequate wages and benefits to recruit and retain nursing staff. The minimum wages for nursing assistants should be raised by 15-20 percent per hour based on the minimum wage calculator by 2022. In addition, any nursing home with an infection outbreak should be required to pay hazard pay above their regular wages to compensate for the risk to staff and ensure adequate staffing during the outbreak. Any additional funding appropriated to nursing homes during an emergency must be used to support wages and benefits for care staff as well as, as necessary, other resident care costs.
 - Require nursing homes to improve worker benefits to ensure sufficient and appropriate staffing in the future. Worker benefits should include providing two weeks of paid sick leave, family leave, and health insurance to all full-time staff. In addition, nursing home employees should have a choice to organize a union and collectively bargain without management interference, with penalties for nursing homes that interfere with union organization efforts.

Improve Enforcement of Minimum Standards of Care

Though federal nursing home standards are strong, substandard care is a widespread and persistent problem. Our studies, as well as numerous federal studies, have identified significant weaknesses in state and federal enforcement. As the COVID-19 pandemic has demonstrated, the failure to adequately monitor and enforce regulatory standards puts vulnerable residents at grave risk.

Recommendations:

1. Increase survey frequency to at least one survey per facility every 6-12 months (rather than 9-15 months). It is the responsibility of state and federal oversight agencies to ensure that residents are safe, receive decent care, and are treated humanely every day. The current 9-15 month inspection cycle has proven to be insufficient and, in the face of any urgent situation (from the COVID pandemic to hurricane season), potentially catastrophic.
2. Improve composition and competency of state (and federal) survey teams:
 - Strongly encourage state survey offices to utilize permanently employed surveyors with minimum reliance on contract surveyors.
 - Improve the caliber of survey agency staff by ensuring that surveyors and managers do not have conflicts of interest (including not being allowed to work in the nursing home industry for at least two years after leaving government service and not being assigned to the same facility for consecutive surveys), and

- ensuring appropriate wages and benefits for state surveyors, especially RN surveyors, to attract and retain a high-quality surveyor and professional workforce.
- Require states to report number and composition of survey staff. Composition to include professional training/accreditation (i.e., nurse, dietician, social worker, etc...), whether permanent or contract staff, and years of experience.
 - Require all survey teams to be multidisciplinary (include individuals with a social work background in addition to persons with a nursing background and experience).
 - Train surveyors in both state and federal regulations and in the meaning and purpose of the laws and regulations: to protect residents and ensure that each is provided good care and quality of life in the facility.
 - Require survey agencies to consult with individuals and entities with expertise and experience in law enforcement, infection control, financial auditing and accounting, and other disciplines useful for evaluating regulatory compliance.
 - Ensure that surveyors are familiar with current care and quality of life practices and standards. To accomplish this, annual training requirements for both state and federal surveyors should include training on:
 - Clinical standards of care, including for pressure ulcers, infection control, and psychotropic drugging; and
 - Current quality of life practices and standards, including for dementia care, cultural competency (such as for communities of color and LGBT individuals), and age and ability appropriate activities.
 - Continue to prohibit state surveyors from providing consultation and training activities for the nursing home industry. Better monitoring of the state agencies is needed to ensure that this prohibition is not violated.
3. Reinstate the definition of Immediate Jeopardy to include violations of minimum standards that have a “potential” for serious harm definition. This definition was in place under the Nursing Home Reform Law of 1987 but was abruptly changed in 2019 (QSO-19-09-ALL).
 4. Review and refine Scope and Severity grid. Numerous studies have indicated that the improper identification of problems, including those relating to serious abuse and neglect of residents, is widespread. For instance, most deficiencies are rated as D (no resident harm) and few violations are identified as G or higher (causing any resident harm or immediate jeopardy).
 5. Develop a quality assurance process to identify, assess, and address patterns of low citations and infrequent identification of resident harm or immediate jeopardy.
 6. Issue guidance to state survey agencies that each violation of regulations should be given its own separate deficiency to stop “stacking” of f-tags. Make separate deficiency for neglect violation, for instance, to help with review/ assessment of data.

Improve Transparency on Nursing Home Quality and Safety

Nursing home information is increasingly accessible to the public thanks to technological advancements and to the 2010 Affordable Care Act. Nonetheless, transparency has not kept up with the growing sophistication of nursing home operators and owners.

Recommendations:

1. Require facilities to report shift-level data on staffing. These data should be publicly available on Care Compare and the underlying databases.
2. Post number of complaints made to both the survey agencies and long-term care ombudsman programs.
3. Post information on all federal and state sanctions, including CMPs (Civil Money Penalties), with information on CMP reductions.
4. Provide information on Care Compare and underlying databases that is searchable not only by individual facilities but also by chain and common ownership.
5. Publish an annual compendium on the quality of care in nursing home chains.
6. Establish and implement mechanisms to independently audit CMS's Quality Measures (QMs). Hold facility owners and operators accountable for the accuracy of self-reported QMs.
7. As appropriate, convert more QMs from self-reported data to claims based data, such as for falls with injuries, pressure ulcers, and psychotropic drug use.
8. Remove self-reported Quality Measures as component of Care Compare's 5-star nursing home rating. (Overall Rating is currently determined by Health Inspection, Staffing, and Quality Measures).
9. Report staffing turnover and tenure as required by the 2010 Affordable Care Act. Establish standards for staffing turnover and issue penalties to facilities with high staff turnover rates.
10. Report MDS resident summary information on the 5-star rating system for age, race/ethnicity, gender, medical conditions, ADLs, Patient Driven Payment Model scores for therapy and nursing, and other related resident information.
11. Provide the plans of correction with the Statements of Deficiencies (Form 2567) on Care Compare, as the states are required to provide on their websites.
12. Cease redacting the 2567s for all but information on individual resident names and room numbers.
13. Improve methodology & practice to address falsification of medical records.
 - Enhance the ability of surveyors to detect and investigate false entries on treatment and medication sign-off sheets and other resident records completed by nursing home staff.
 - Place an equal burden of proof on the facility to prove that a particular care or quality of life need *is* being provided in a proper manner other than the daily sign-off sheets, rather than placing the entire burden of proof that a particular care or quality of life need is *not* being provided on the resident and family. For

example, it should not be necessary to wait until pressure ulcers become serious (or deadly) before a citation for lack of preventative care can be issued.

Improve Ownership and Financial Accountability

Over the years, the nursing home industry has become increasingly sophisticated. The result has been detrimental for taxpayers (who pay for the large majority of nursing home care) and, too often, catastrophic for America's nursing home residents and families.

Recommendations:

1. Promulgate federal regulations specifying minimum criteria for the purchase (or change of ownership) or management of any nursing home. The criteria should prevent individual or corporate owners from purchasing, operating, or managing additional facilities if they have a history of owning or operating other facilities with chronically low staffing and poor-quality care in any state. Companies with corporate settlements for fraud, substandard care, or "worthless services" should be barred from purchasing new nursing homes for five years.
2. Establish a national prior approval process for changes in ownership or management. To implement these requirements, CMS should establish a centralized application unit for ownership and management evaluations, with processes delineated to work with state agencies, state attorneys general, and the DOJ. Finally, CMS should establish minimum per-day penalties for any owner or operator who has not received prior approval for a licensee or a change of ownership, including an automatic denial of payments.
3. In posting of a facility's ownership information, provide the names of each owner's other facilities, with links to their Care Compare page. Post the name of the owner of the nursing home's real estate, indicating whether the entity owning the real estate is related to the operator. Require posting the names of private equity investors.
4. Post archival data for nursing homes (minimum five years) including information on name changes, change of ownership, or change in type of sponsorship.
5. Establish an ownership review unit that audits the ownership data provided by nursing homes. Ensure enforcement of Section 6101 of the ACA, including that companies provide a complete organizational chart. Failure to provide such complete and accurate data should result in specified financial penalties until the information is provided.
6. Augment PECOS reporting to include all parent, management, property companies, and other related party entities and make the data publicly available in a searchable format.
7. Amend cost report requirements to require each nursing home to provide annual consolidated financial reports that include data from operating entities (license holders) and all organizations and entities related by common ownership or control. The reports should provide flow charts of all related party entities including home offices, management organizations, staffing, therapy, supply, pharmaceutical, consulting, insurance, banking, investment entities, parent companies, holding companies, and sister organizations. Management companies and property companies should also be

required to provide a full financial report annually. The cost reports should be prepared by a certified public accounting firm.

8. Establish a combined financial and oversight system to conduct annual joint Medicare and Medicaid audits. This should include home office and related-party payer audits, with penalties levied for inaccurate cost data. As part of the audit oversight, CMS should be given full access to Internal Revenue Service filings of entities involved in the nursing home operation.
9. Redesign Medicare nursing home cost reports to report the details of administrative costs and profits for the operating entities as well as all related party organizations.
10. Make the Medicare cost reports fully accessible to the public in an Excel or user-friendly format.

Correct Other Operational Biases Toward Facilities

Many of the recommendations proposed in this document respond to policies and practices which favor the nursing home industry priorities over the needs of residents. For example, though nurse staffing has long been recognized as critical for ensuring resident safety and dignity, the majority of nursing homes persistently fail to meet the minimum safe staffing levels identified in [CMS's 2001 staffing report](#). The following recommendations address some of the systemic biases which marginalize the voices of residents and their families.

Recommendations:

1. Informal Dispute Resolution (IDR).
 - In cases stemming from a complaint, open hearings to allow a complainant or a complainant's representative to participate. In survey cases, extend an invitation for representatives from both the Resident and Family Councils to participate.
 - Complainants should have the equivalent right as facilities to call their own IDR when they disagree with a ruling, citation of deficiency, or lack of a citation of deficiency. To only provide the IDR option to facilities sends a clear signal to the entire nursing home community (including residents, workers, administration and, importantly, the surveyors themselves) that the fairness and efficacy of the survey process is centered on the facility and its needs and resources, rather than on the needs of the residents (for whom, presumably, the entire system exists) and the provision of care and quality of life that meets or exceeds minimum standards.
 - The outcome of the IDR and the basis for that outcome should be disclosed in a public report (redacted, if necessary, to protect individuals' privacy).
2. Allow consumers, including resident and family councils, to appeal complaint and other survey results (for the same reasons stated above, re. IDR).
3. Weight equally the observations by residents, family members, LTC ombudsman, staff, and other observers.
4. Take concrete steps to ensure that the regulations and guidance relating to resident dignity and quality of life, including those promulgated in 2009, are effectuated. As CMS

staff noted in 2009, these are longstanding requirements that are essential components of the Reform Law and its implementing regulations. Our observations, experience and knowledge all indicate that, in practice, care issues remain the primary focus of enforcement while quality of life and resident and family rights are enforced to a much lesser extent or not at all.

5. Clarify and enhance the rights of resident and family councils.
 - Federal law requires that facility listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.
 - It is the experience of many consumers that this regulation is rarely enforced and, when it is, family and resident council complaints are rarely (if ever) rated at a level higher than D or E. Thus, functionally, CMS's position seems to be that while resident and family councils do have the right to express grievances and make recommendations, the facility need not take them seriously.
 - Similarly, though state surveyors have been required to listen to and investigate concerns raised by resident and family councils since surveyor protocols were changes in 2017, our knowledge and experience indicate that state surveyors often are not receptive to concerns raised by the council.
6. Collaboration between CMS and industry.
 - Survey processes must prioritize residents; it is not in the best interests of residents to make the survey more collaborative and less punitive.
 - Any collaboration between the federal government and providers must not be connected to the regulatory divisions. Enforce federal surveyor conflict of interest provisions against providing consultation.
 - Quality Improvement Organization (QIO) programs should be assessed for effectiveness and should not supplant (and, thereby, undermine) the minimum federal requirements for nursing home competency.

Improve the Use of CMP Funds by the State & CMS

States are permitted to retain a portion of civil money penalties (CMPs) to invest in project that will improve care and quality of life for residents. While some progress has been made over the years in respect to transparency and quality, too much of these limited, precious funds are still used for purposes that contradict longstanding federal requirements.

Recommendations:

1. Update guidance to further clarify appropriate uses, specifically the prohibition against using funds to assist nursing homes in meeting existing responsibilities. For instance, example #7 in [S&C: 12-13-NH](#) should be removed, since nursing homes are already paid to provide effective fall prevention and pressure ulcer care.
2. Publish and publicize, on annual basis, state and CMS use of CMP funds, including links to funded projects.
3. Publish and publicize, on annual basis, state and CMS CMP reinvestment fund balances.