LTCCC Webinar

Nursing Home Staffing A to Z

www.nursinghome411.org

The Long Term Care Community Coalition

- **LTCCC**: Nonprofit, nonpartisan organization dedicated to improving care & quality of life for the elderly & adult disabled in long-term care (LTC).
- **Our focus**: People who live in nursing homes & assisted living.
- **What we do**:
  - Policy analysis and systems advocacy;
  - Data resources & analyses;
  - Education of consumers and families, LTC ombudsmen, and other stakeholders;
  - Home of two local LTC Ombudsman Programs.
- **Website**: www.nursinghome411.org.

Outline of Today's Program

BACKGROUND: Federal law & standards for nursing homes.

FINDING THE DATA: How to find information on the staffing levels in your facility or those in your state or community.

KEY INSIGHTS: How the data points can drive improvements both at the facility level and in shaping broader policy decisions.

LTCCC Resources.

Background

The Nursing Home Reform Law

- The law passed in 1987.
- ***Every*** nursing home that participates in Medicaid/Medicare agrees to meet or exceed federal standards.
- The law emphasizes individualized, patient-centered care.
- ***Every*** nursing home resident must be provided the care and quality of life services sufficient to attain and maintain their highest practicable physical, emotional, & psycho-social well-being.
- Importantly, the law lays out specific resident rights, from good care to a quality of life that maximizes choice, dignity, & autonomy.
- **Sufficient staffing** has been required since the beginning.

States can provide additional rights.

Federal Nursing Home Staffing Requirements

LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

CONSUMER FACT SHEET: REQUIREMENTS FOR NURSING HOME CARE STAFF & ADMINISTRATION

Staffing is widely considered to be the most important factor in the quality of care provided in a nursing home. Too often, facilities fail to have sufficient staff or the staff does not have the appropriate knowledge and competencies to provide the care residents need. Thus, federal requirements for sufficient and competent staff are critical to support resident-centered advocacy to ensure that residents are safe and that they receive appropriate services. This is what we pay for and what every facility agrees to provide for all of its residents when it participates in Medicaid/Medicare.

Below are relevant standards with descriptions excerpted from the federal regulations, followed by some points for you to consider when you advocate on these issues. [Note: The brackets below provide, for reference, the applicable federal regulation (42 CFR) and the F-tag number used when a facility is cited for failing to meet the standard.]

I. Fundamental Requirements for Nursing Services [42 CFR 483.35 F-725]

The facility must have sufficient nursing staff *with the appropriate competencies and skills sets* to provide nursing and related services to *assure resident safety and* attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care *and considering the number, acuity and diagnoses of the facility's resident population….*

II. Sufficient Staffing Levels [42 CFR 483.35(a) F-725]

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) …licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.

III. Nurse Aide Competency [42 CFR 483.35(d) F-728]

***General rule**. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless—*

That individual is competent to provide nursing and nursing related services; and

That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State…; or

That individual has been deemed or determined competent [based on long-term experience and other federal requirements]….

***Non-permanent employees**. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the [above] requirements….*

THINGS TO CONSIDER:

- Does the nursing home have enough staff on the floor to meet residents' needs in a timely manner? This includes…
  - Resident call bells responded to in a timely fashion.
  - Residents not being put into diapers because there are not enough staff to help them go to the bathroom.
  - Residents getting baths/showers at a time and frequency of their choosing.
  - Residents waking up and going to bed at a time of their choosing.
- Are staff finding and implementing options that most meet the physical and emotional needs of each resident?
- Are the assessment and care planning processes identifying and seeking ways to support residents' individual needs?
- Are those processes being implemented by care staff across shifts?
- Are staff informing residents and those they designate about the resident's health status and health care choices and their ramifications?
- Does the facility administration and environment promote actions by staff that maintain or enhance each resident's dignity?
- Do staff interaction with residents display full recognition of each resident's individuality? Is this occurring during different shifts and on weekends?
- Is the nursing home providing alternatives to drug therapy or restraints by understanding and communicating to staff why residents act as they do, what they are attempting to communicate, and what needs the staff must meet?
- Is the nursing home actively assisting residents with discharge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home)?
- Are staff members assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions?
- Does the nursing home actively assist in making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation)?

Federal Nursing Home Staffing Requirements

LONG TERM CARE COMMUNITY COALITION
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THE ROLE OF MEDICAL DIRECTORS IN NURSING HOMES
FACT SHEET

Federal rules require that every nursing home has a medical director. Under the rules, they play a critical role in the care of residents in nursing homes.

Unfortunately, low medical director staffing is the norm in U.S. nursing homes. As a result, the care of residents in too many U.S. nursing homes lacks the professional oversight and input that only a trained and licensed physician can provide.

This fact sheet provides user-friendly information on the role of the medical director, why their presence in the facility is important to resident care and safety, and advocacy tips for residents, families, and those who work with them.

Note: Information below is directly quoted or paraphrased from the Code of Federal Regulations (CFR),[1] federal guidance, or other resources (see footnotes). Federal standards are applicable to all residents in licensed U.S. nursing homes, including short-term, long-term, private pay, Medicaid, Medicare, or privately insured.

Medical Director [42 C.F.R. § 483.70(h); F841]

"Medical director"[2] means a physician who oversees the medical care and other designated care and services in a health care organization or facility. Under these regulations, the medical director is responsible for coordinating medical care and helping to implement and evaluate resident care policies that reflect current professional standards of practice.

1. The facility must designate a physician to serve as medical director.
2. The medical director is responsible for –
   i. Implementation of resident care policies; and
   ii. The coordination of medical care in the facility.

The facility must identify how the medical director will fulfill their responsibilities to effectively implement resident care policies and coordinate medical care for residents in the facility. Furthermore, the facility must ensure all responsibilities are effectively performed to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being.

Medical director responsibilities must include their participation in:

- Administrative decisions including recommending, developing, and approving facility policies related to resident care;
- Issues related to the coordination of medical care identified through the facility's quality assessment[3] and assurance committee;
- Organizing and coordinating physician services and services provided by other professionals as they relate to resident care;
- Participate in the Quality Assessment and Assurance (QAA) committee or assign a designee to represent them.

Medical Director vs. Attending Physician

While many medical directors also serve as attending physicians, the roles and functions of a medical director are separate from those of an attending physician. The medical director's role involves the coordination of facility-wide medical care while the attending physician's role involves primary responsibility for the medical care of individual residents.

It is important for residents and families to know that they have a right to choose their own attending physician. For more information, see LTCCC's fact sheet, Requirements for Nursing Home Physician, Rehab, & Dental Services.

Resident-Centered Advocacy Tips

- Though too often overlooked by residents and those who work with them, it's important to remember that, **when it comes to the clinical care in a nursing home, the buck stops with the medical director**.
- Use information on your facility's medical director presence to support your advocacy. **Visit www.nursinghome411.org for the latest staffing data. Our Nursing Home Staffing Data page includes information on nurse staffing and non-nurse staffing, including medical directors.**
  - Find out the medical director staffing levels for your facility.
  - Choose a facility with a meaningful medical director presence.
  - If there is little or no medical director time in the facility, ask how the important responsibilities outlined in this fact sheet are being performed. **Who's overseeing care if there's no one there?**
- Find out who your facility's medical director is. While it would not be productive to bring every problem to the medical director's attention, persistent, widespread, and/or endangering residents speak directly to the medical director's duties.
- Concerns about problems related to the medical director's duties can also be raised via the facility grievance process, with the LTC Ombudsman Program, and by filing a complaint with the state Medicaid Fraud Control Unit or health department. Use the information in this fact sheet to precisely support your complaint. [See LTCCC's Abuse, Neglect, & Crime Reporting Center for contact information state and federal agencies.]
- Resident and family councils can be particularly powerful in advocating on fulfillment of medical director responsibilities, since they speak as a group and can present share concerns with relative anonymity.

[1] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.24.
[2] *See* CMS State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities. Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.
[3] See LTCCC's Fact Sheet: Tips for Providing Input on Your Nursing Home's Staffing Assessment. Available at https://nursinghome411.org/input-tips-facility-assessment/.

Federal Nursing Home Staffing Requirements

- The federal rules have specific requirements for these and other staffing categories, including activities staff, social workers, pharmacy staff, etc….
- For more information on the requirements for key nursing home staffing categories, visit LTCCC's Fact Sheet page at **www.nursinghome411.org/learn/facts/**

Federal Nursing Home Staffing Requirements

Equally important to the requirements *for* staff are the requirements *for* resident care and services.

- Services must be sufficient to assure that each resident is able to attain and maintain their highest practicable physical, emotional, and psycho-social well-being.
- This includes having sufficient, appropriately trained staff to provide…
  - Good dementia care
  - Help with bathing and toileting in a timely manner
  - Activities that are meaningful to residents, including those with dementia
  - Medication that is accurate and provided on time
  - Therapy to meet every resident's care goals
  - And more!

New Federal Minimum Staffing Standards

1. **24/7 registered nurses (RNs)**. Currently, nursing homes are required to have a RN eight hours per day, with the other 16 LPN or RN.

2. **Minimum overall nursing staff of 3.48 hours per resident per day (HPRD). This must include .55 HPRD of RN time and 2.45 HPRD of CNA time.** Previously, there were no *quantitative* federal minimum staffing requirements.

3. **Facilities must conduct assessments** to ensure sufficient resources and staff to meet resident needs.

These new standards do *not* supplant a facility's longstanding requirement to provide sufficient staffing.

New Federal Minimum Staffing Standards – **Exemptions**

Facilities in a "workforce shortage area" (identified as an area where the RN/CNA to population ratio is 20% below the national average) and which have documented a "good faith effort" to hire staff will qualify for an exemption from the aforementioned minimum staffing requirements. Exemptions are in effect until the next standard survey.

Ineligible for exemptions.

- Special Focus Facilities;
- Facilities that fail to report PBJ staffing data;
- Facilities that have a widespread pattern of insufficient staffing that has resulted in serious harm or death to a resident w/in last 12 months.

New Federal Minimum Staffing Standards – **Implementation**

Delayed implementation.

- **For all facilities**. Compliance with facility assessment requirements 90 days after the publication date of the final rule.
- **For rural facilities**.
  - The requirement related to providing 3.48 HPRD for total nurse staffing and the requirement related to 24/7 onsite RN at § 483.35(c)(1) must be implemented 3 years after the publication date of this final rule.
  - The requirements related to providing 0.55 RN and 2.45 NA HPRD at must be implemented 5 years after the publication date of this final rule.
- **For non-rural facilities**.
  - The requirement related to providing 3.48 HPRD for total nurse staffing at and the requirement related to 24/7 onsite must be implemented 2 years after the publication date of this final rule.
  - The requirements related to providing 0.55 RN and 2.45 NA HPRD at must be implemented 3 years after the publication date of this final rule.

New Federal Minimum Staffing Standards – **Facility Assessment**

Current requirements:

- Nursing homes must conduct and document a facility-wide assessment to determine what resources are necessary to care for its resident population competently during both day-to-day operations and emergencies.
- It must be reviewed and updated annually, as necessary, and whenever the facility plans for or has any change in its facility or population that would require a substantial change to any part of the assessment.
- The assessment must address or include evaluation of the resident population, the facility's resources, and a facility-based and community-based risk assessment that utilizes the all-hazards approach.

New Federal Minimum Staffing Standards – **Facility Assessment**

New requirements:

- "We are further modifying the requirements to ensure that facilities have an efficient process for consistently assessing and documenting the necessary resources and staff that the facility requires to provide ongoing care for its population that is based on the specific needs of its residents."

- "[T]he active participation of the nursing home leadership and management including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and, direct care staff, including but not limited to, RNs, LPNs/LVNs, Nas, and representatives of direct care staff, if applicable. The LTC facility must also solicit and consider input received from residents, resident representatives, family members."

New Federal Minimum Staffing Standards – **Facility Assessment**

New requirements (continued):

- The facility assessment requirement as set forth at § 483.71 is a separate requirement that is designed to ensure that each LTC facility has assessed its resident population to determine the resources, including direct care staff, their competencies, and skill sets, the facility needs to provide the required resident care.
- If the facility assessment indicates that a higher HPRD for either total nursing staff or an individual nursing category is necessary for "sufficient staffing", the facility must comply with that determination to satisfy the requirement for sufficient staffing as set forth at § 483.35(a)(1).
- The facility assessment requirement ensures that each LTC facility assesses the needs of its resident population to determine the resources it needs to provide the care its residents require.
- However, if the facility assessment indicates that a lower HPRD or that a 24/7 RN is not required to care for their resident population, the LTC facility must still comply with those minimum staffing requirements.

Industry Lawsuit…

- AHCA filed a lawsuit in the Northern District of Texas to set aside the staffing rule, arguing
  1. Under the Administrative Procedure Act, HHS & CMS exceeded their authority and
  2. The rule is arbitrary and capricious.
- LeadingAge subsequently joined lawsuit.
- Lawsuit targets the numerical staffing requirements, ***not*** the assessment requirement.
- Following the US Supreme Court's decision in *Loper*, we believe it is extremely likely that the industry will prevail. [*Loper* overturned *Chevron USA v. National Resources Defense Council* (1984) and the federal judiciary's practice of deferring to agencies' reasonable interpretations of ambiguous federal laws.]

What Data Are We Talking About…

…And Why Do They Matter?

How Do Nurse Staffing Levels Impact Quality, Safety, & Dignity?

- Numerous studies over the years have shown that there is a strong correlation between nurse staffing levels and quality.
- The relationship between RN staffing and quality is particularly strong.
- A 2001 landmark federal study found…
  - 4.1 HPRD (Hours Per Resident Day) of total nursing time is needed just to provide sufficient clinical care.
  - .75 HPRD of that time should be by a RN.
- The 2001 study did not include time necessary to meet federal requirements for resident dignity or psycho-social well-being.
- The 2001 study did not account for time to implement effective infection control protocols (a widespread and persistent problem well before the COVID pandemic.
- A more recent federal study found no upper limit to the benefits of higher staffing.

Sufficient staffing benefits both residents and care staff.

All Staffing Matters!

- The role of nursing staff in resident care is well-documented.
- Though non-care staff have important roles under the federal standards in ensuring appropriate care and services, little is known about the extent to which they are actually present in nursing homes to fulfill those roles.
- LTCCC has been studying the extent to which the people fulfilling these roles are present in the nursing home.
- To our knowledge, this is the first time that anyone has studied non-nurse staffing levels and their implications for resident care.

LTCCC's study found alarming gaps in medical director coverage in US nursing homes. www.nursinghome411.org/alert-medical-director-study/

Who are we talking about?

Nursing homes employ a wide variety of staff, from the CNAs, LPNs, and RNs who provide direct care and monitoring to administrative and support staff.

Since 2016, nursing homes have been required to report information on a range of staff that are in their facility every day on a quarterly basis.

Nursing Staff Include…

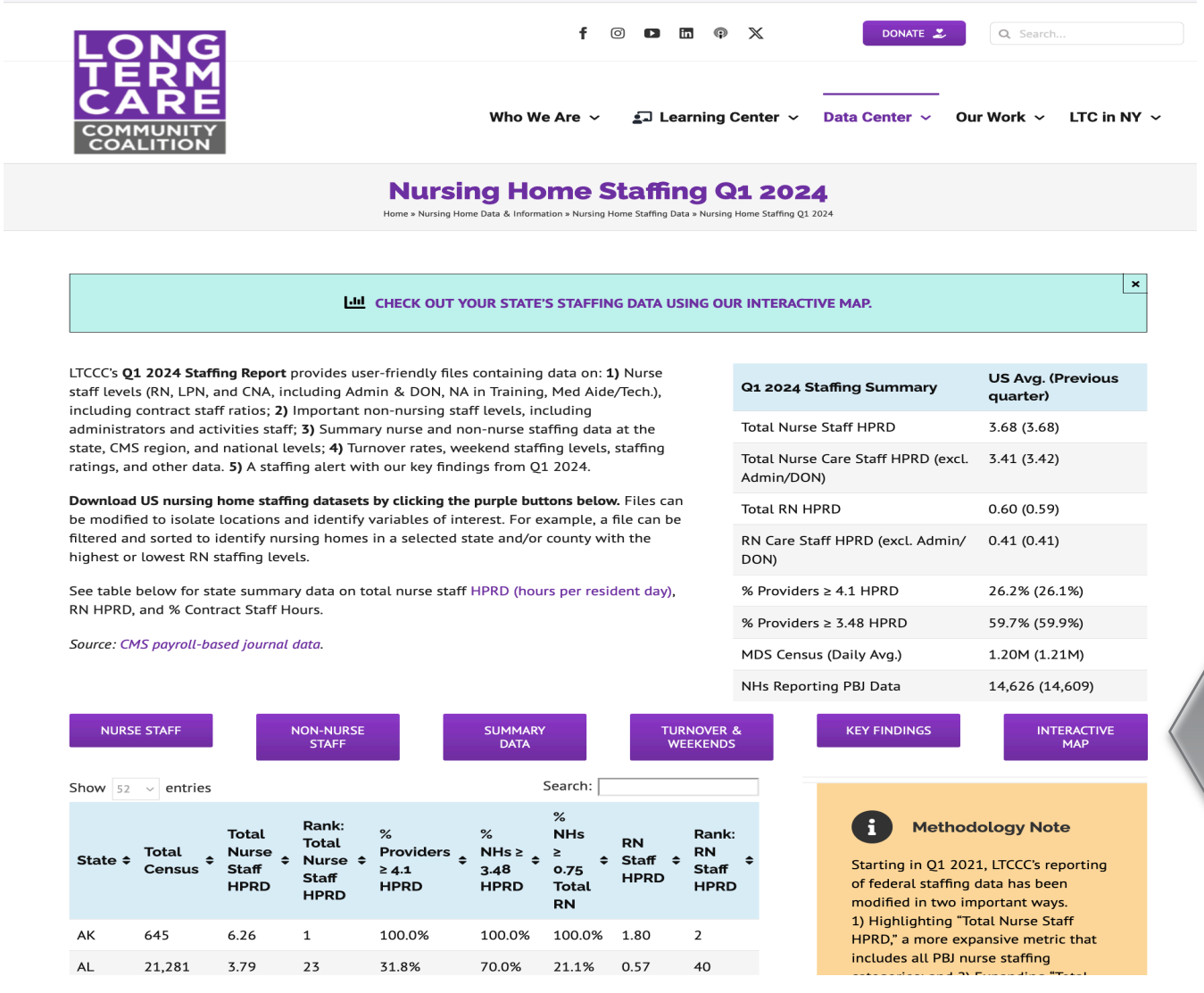
- Registered Nurses
  - Director of Nursing
  - Administrative vs Care
- Licensed Practical/Vocational Nurses
  - Administrative vs Care
- Certified Nurse Aides
  - In Training vs Certified

Non-Nursing Staff Include…

- Administrator
- Medical Director
- Pharmacist
- Dietician
- Social Workers
  - Qualified vs Mental Health vs Other
- Occupation & Physical Therapists
  - Professional vs Assistant vs Aide
- Activity
  - Professional vs Other

In addition, contract vs. employee status is provided.

Finding & Using Nursing Home Staffing Information



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Nursing Home Staffing Q1 2024

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CHECK OUT YOUR STATE'S STAFFING DATA USING OUR INTERACTIVE MAP.

LTCCC's **Q1 2024 Staffing Report** provides user-friendly files containing data on: **1)** Nurse staff levels (RN, LPN, and CNA, including Admin & DON, NA in Training, Med Aide/Tech.), including contract staff ratios; **2)** Important non-nursing staff levels, including administrators and activities staff; **3)** Summary nurse and non-nurse staffing data at the state, CMS region, and national levels; **4)** Turnover rates, weekend staffing levels, staffing ratings, and other data. **5)** A staffing alert with our key findings from Q1 2024.

Download US nursing home staffing datasets by clicking the purple buttons below. Files can be modified to isolate locations and identify variables of interest. For example, a file can be filtered and sorted to identify nursing homes in a selected state and/or county with the highest or lowest RN staffing levels.

See table below for state summary data on total nurse staff HPRD (hours per resident day), RN HPRD, and % Contract Staff Hours.

Source: CMS payroll-based journal data.

Q1 2024 Staffing Summary	US Avg. (Previous quarter)
Total Nurse Staff HPRD	3.68 (3.68)
Total Nurse Care Staff HPRD (excl. Admin/DON)	3.41 (3.42)
Total RN HPRD	0.60 (0.59)
RN Care Staff HPRD (excl. Admin/DON)	0.41 (0.41)
% Providers ≥ 4.1 HPRD	26.2% (26.1%)
% Providers ≥ 3.48 HPRD	59.7% (59.9%)
MDS Census (Daily Avg.)	1.20M (1.21M)
NHs Reporting PBJ Data	14,626 (14,609)

NURSE STAFF | NON-NURSE STAFF | SUMMARY DATA | TURNOVER & WEEKENDS | KEY FINDINGS | INTERACTIVE MAP

Show 52 entries Search:

State	Total Census	Total Nurse Staff HPRD	Rank: Total Nurse Staff HPRD	% Providers ≥ 4.1 HPRD	% NHs ≥ 3.48 HPRD	% NHs ≥ 0.75 Total RN	RN Staff HPRD	Rank: RN Staff HPRD
AK	645	6.26	1	100.0%	100.0%	100.0%	1.80	2
AL	21,281	3.79	23	31.8%	70.0%	21.1%	0.57	40

Methodology Note

Starting in Q1 2021, LTCCC's reporting of federal staffing data has been modified in two important ways.
1) Highlighting "Total Nurse Staff HPRD," a more expansive metric that includes all PBJ nurse staffing

Searchable Files

www.nursinghome411.org/data/staffing

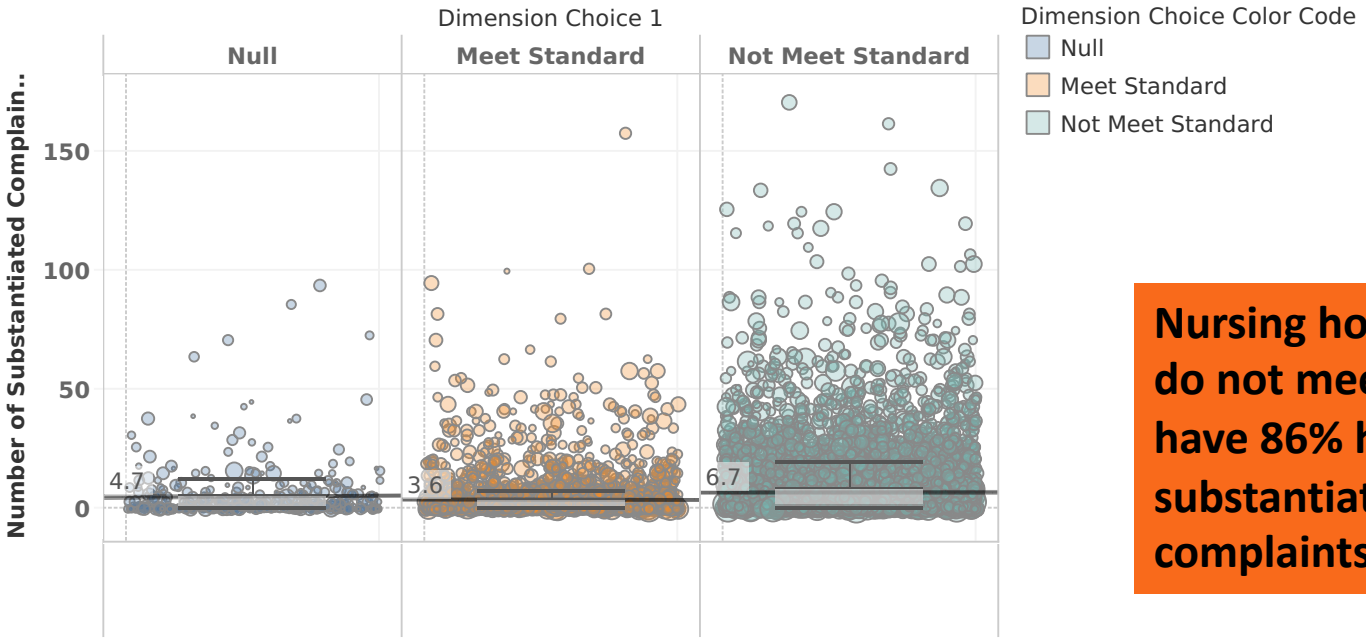
Review of LTCCC's Public Staffing Files

Data Insights

How Do We Know – And Show – That Staffing Matters?

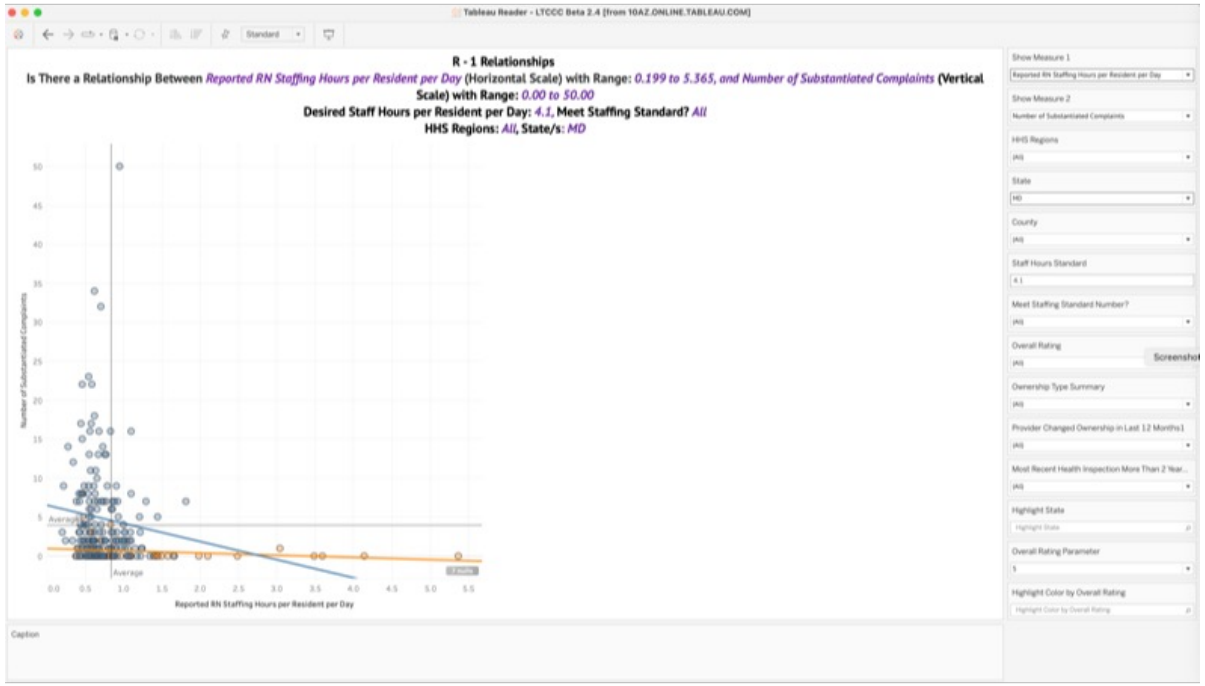
Why is Sufficient Staffing So Important?

Does Measure *Number of Substantiated Complaints* (Vertical Scale) with Range: 0.0 to 171.0*, vary by Meet Staff Standard* (Horizontal Scale)?
Color by *Meet Staff Standard* , Desired Staff Hours per Resident per Day: *4.1,* Meet Staffing Standard? *All*
Ownership Type: *All*, HHS Regions: *All*, State/s: *All*



Nursing homes that do not meet 4.1 HPRD have 86% higher substantiated complaints.

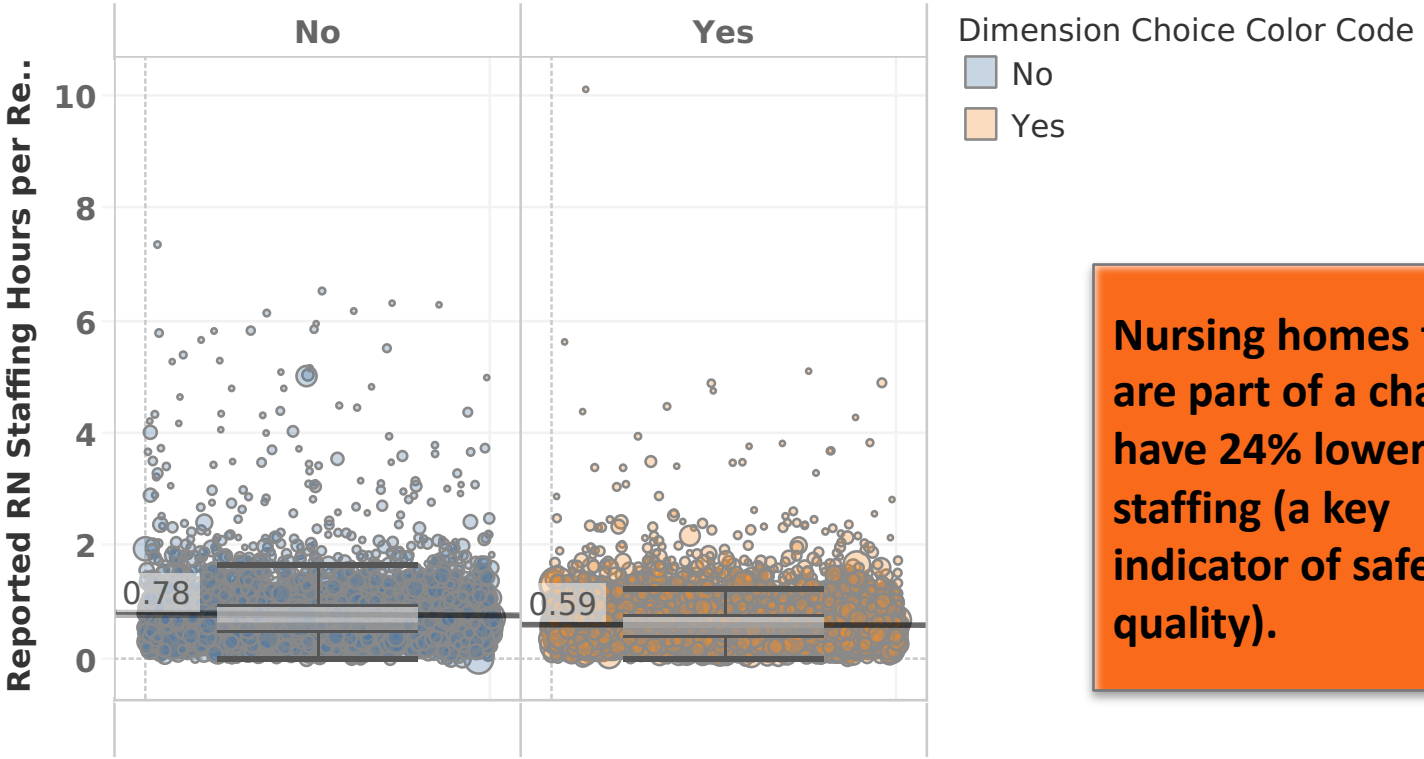
Relationship between RN staffing levels and substantiated complaints in US nursing homes



As RN staffing levels go up substantiated complaints go down.

Impact of Chain Ownership on Staffing

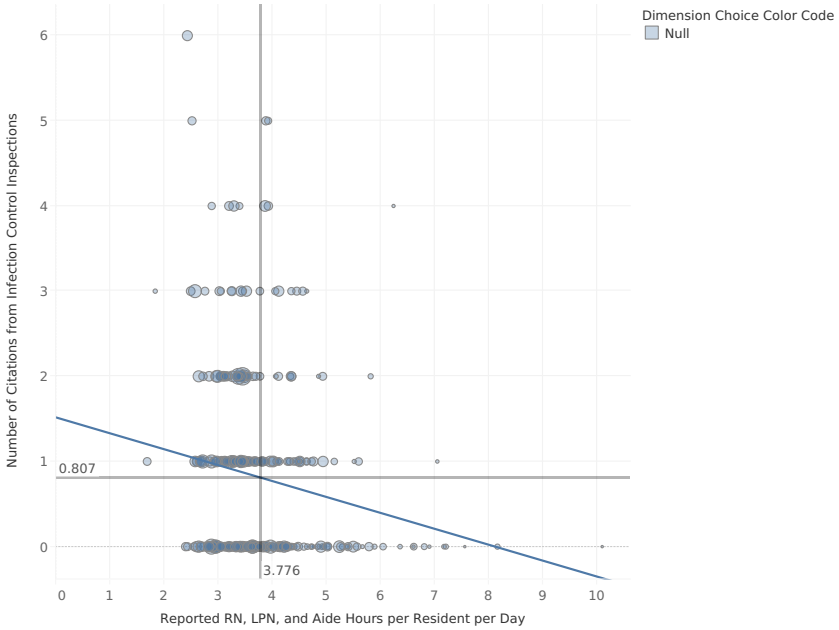
Ownership Summary: *For profit, Government, Non profit*, HHS Regions: *Region 1, Region 10, Region 2 and 7 more*, State/s: *All*



Nursing homes that are part of a chain have 24% lower RN staffing (a key indicator of safety and quality).

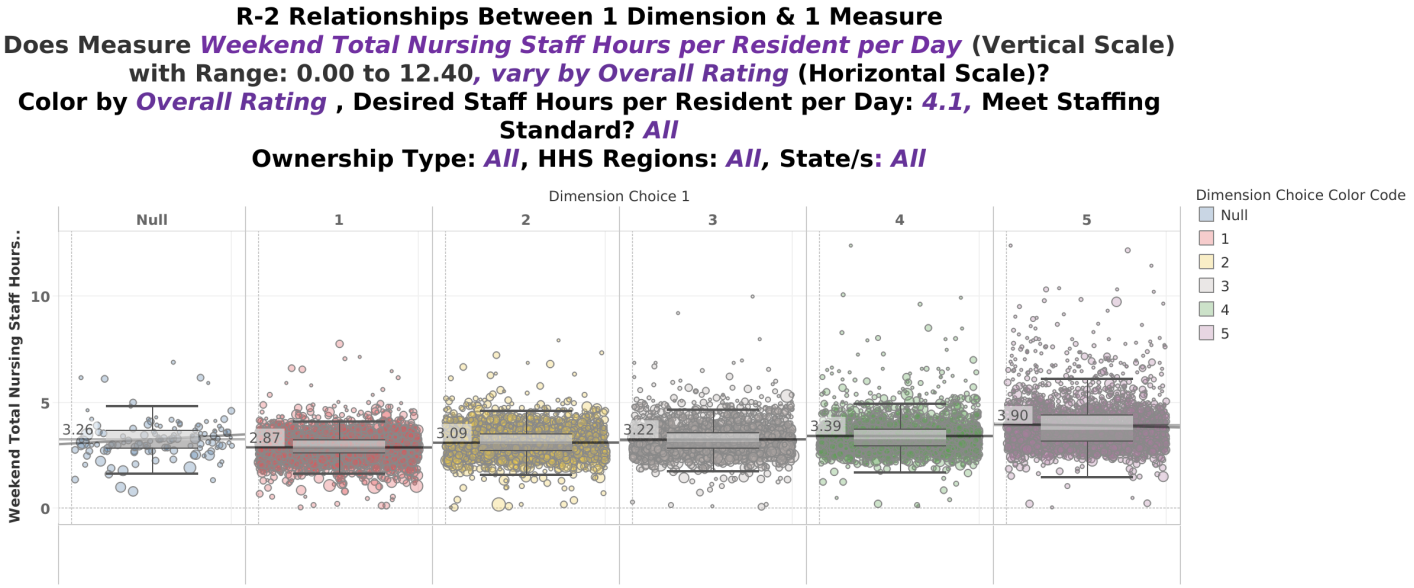
Relationship Between Nurse Staffing Levels & Infection Control Citations (New Jersey)

R-1 Relationships Between Two Measures
Is There a Relationship Between *Reported RN, LPN, and Aide Hours per Resident per Day* (Horizontal Scale) with Range: 1.683 to 10.091, *and Number of Citations from Infection Control Inspections* (Vertical Scale) with Range: 0.000 to 6.000
Color by *None* , Desired Staff Hours per Resident per Day: *4.1,* Meet Staffing Standard? *All*
Ownership Type: *All*, HHS Regions: *All*, State/s: *NJ*



Infection control violations go down as nurse staffing goes up.

Relationship Between Weekend Nurse Staffing Levels & Star Rating



One-star nursing homes had an average weekend staffing of 2.87 HPRD. Five-star homes had an average weekend staffing of 3.90 HPRD.

Can Nursing Homes Hire More Staff?

Dispelling the Industry's False & Dishonest Narrative

Staffing

- Staffing is the most important predictor of the quality and safety of a nursing home's care.
- Nevertheless, most facilities fail to maintain sufficient staff to even meet basic clinical needs of their residents.
- ***Industry lobbyists claim:***

1. They cannot find care staff and
2. They don't get enough $$ to hire sufficient staff.

- ***Both of these claims are dishonest:***

1. The typical nursing home has 50%+ annual turnover and
2. In the absence of effective oversight, many operators maximize profits by cutting staffing.

In any case, nursing homes are not warehouses.

Myth: Nursing home payment is insufficient to provide good care.

Reality: Most nursing homes are run for-profit and are seen as attractive investments.

- The industry's longstanding argument that it does not get paid enough to provide sufficient staffing, baseline infection control protocols, etc… is unsubstantiated.
- In fact, nursing homes are increasingly operated by for-profit entities.
- Sophisticated private enterprises and REITs have increasing, substantial investment in the sector.
- There are virtually no limitations on the use of public funds to pay for administrative staff or siphon off into profits.
- Operators commonly use related party transactions to hide profits (and perpetuate the myth of "razor-thin margins").

+ Medicaid Funding

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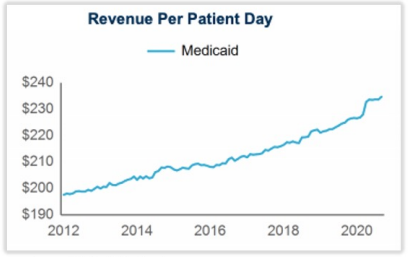
LTCCC POLICY BRIEF

NURSING HOME MEDICAID FUNDING: SEPARATING FACT FROM FICTION

Background. Medicaid is the primary funding source for the majority of nursing home services in the US. Managed by states using a mix of state and federal funding, Medicaid covers more than 60% of residents nationwide. Each state has broad flexibility to determine eligibility standards and payment methods and design reimbursement rates.

Industry Claims vs. Facts. Nursing home providers and trade associations claim that Medicaid rates are inadequate and less than the cost of actual care. The industry also blames low Medicaid rates for substandard care. However, recent studies suggest that for-profit facilities have maximized profits for owners and investors while skimping on resident care.

- Medicaid rates have steadily increased in the past decade, rising 12.6% since 2012, according to the National Investment Center for Seniors Housing & Care (NIC).
- Nursing homes received an average of $214 per resident per day in Medicaid funding in 2019, a 2.2% increase from 2018.



Source: NIC MAP Data Service

- An NIC report with data through September 2020 shows a national average reimbursement rate of $235, though this $21 increase from 2019 is likely a COVID-related boost.
- Although industry leaders claim that nursing homes are losing money on Medicaid residents and blame closures and financial struggles on low reimbursement rates, typical nursing home profits are in the 3 to 4 percent range, according to Bill Ulrich, a nursing home financial consultant. This does not include profits that are hidden in related-party transactions, which 75% of nursing homes report, or bloated administrative costs. Numerous studies and reports have shown that related-party transactions can be used to "siphon off higher profits, which are not recorded on the nursing home's accounts," giving the false impression that a nursing home has low profits or is losing money."

209 West 29th Street, New York, NY 10001 | P: 212-385-0355 | E: info@ltccc.org
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Lack of Accountability. Bolstered by government funding, providers are raking in profits while facing limited accountability for how they utilize Medicaid funds. Though not illegal, operators too often utilize Medicare and Medicaid funds by using public reimbursement to cover salaries, administrative costs, and other non-direct care services. Without transparency and accountability, determining the extent to which Medicaid rates cover the costs of care for Medicaid nursing home residents is simply not possible. Providers must be held accountable for their finances in order to safeguard residents from owners and operators who prioritize profits while providing grossly substandard care.

> **"Just enough is spent on Medicaid residents to keep state inspectors satisfied, while, at the same time, Medicare patients are not given the full value of their insurance coverage."**
>
> – Will Englund and Joel Jacobs, *The Washington Post*

Conclusion. Nursing homes do, in fact, receive frequent increases in funding, including Medicaid reimbursement. Though Medicaid pays for the majority of nursing home services, there is virtually no transparency or accountability in respect to how facilities actually use these funds. In the absence of federal limits on diverting public funds to hide profits in contracts with related parties or in inflated administrative costs, the industry's argument that it does not receive enough money to provide sufficient staffing and good care is inaccurate (if not fraudulent).

The growth of for-profit ownership in nursing homes over the years, including significant investment by private equity firms and real estate investment trusts (REITs), make it clear that nursing homes are profitable businesses which, in the absence of government quality assurance, too often sacrifice resident safety in order to maximize profits. More financial accountability for facilities would decrease the likelihood of facilities funneling cash to owners and investors at the expense of better resident care.

The Long Term Care Community Coalition is a non-profit, non-partisan organization dedicated to improving care and dignity for individuals in nursing homes and other residential care settings. Visit our homepage, www.NursingHome411.org, for resources and information on nursing home policy issues.

This policy brief is part of a new series on reimagining nursing home care in the wake of the devastation wrought by the coronavirus pandemic. To sign up for future alerts, visit https://nursinghome411.org/join/.

Medicare Funding

According to the Medicare Payment Advisory Commission…

- The average marginal profit from Medicare nursing home patients in 2021 was 17.2%.
- The average Medicare profit margin has been above 10% for over 20 years.

Unfortunately, the focus of Medicare rate setting has been almost entirely on controlling costs rather than ensuring quality. Medicare prospective payments are based on estimated costs and not on actual expenditures. This system allows nursing homes to keep staffing and operating expenses low in order to maximize profits.

NOTE: These profit margins do not take into account profits hidden in administrative costs or related-party transactions.

* Medicare Payment Advisory Commission, *Data Book: Health Care Spending and the Medicare Program,* July 2023.

OIG: *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*

- OIG found that **one-third of residents who were in a nursing home for short-term care were harmed** w/in an average of 15.5 days.
- **Almost 60 percent of the injuries were preventable and attributable to poor care**.
- Much of the **preventable harm was due to substandard care**, inadequate resident monitoring, and failure or delay of necessary care.
- As a result, six percent of those who were harmed died, and more than half were rehospitalized.

Even when profits are high, nursing homes fail to provide adequate care, safety, or treat residents humanely.

Nursing Home Data Updates

Information on Operators & Chains

Provider Data

ral information on currently active nursing homes, including
quality measure scores, staffing, and other information used in
n.

more info on ratings, staffing, data categories, and footnotes.

ov/provider-data/dataset/4pq5-n9py.
and released May 29, 2024.

Filter by State(s)

MA	MD	ME	MI	MN
MO	MS	MT	NC	ND
NE	NH	NJ	NM	NV
NY	OH	OK	OR	PA

CMS Region Number

2	1	3	4	5
6	7	8	9	10

Ownership Type

- For profit
- Government
- Non profit

Provider Name	City/Tow	County/Paris h	Problem Facility (1 star and/or SFF, SFF Candidat	Ownership Type	Number of Certified Beds	Average Number of Residents per Day	Average Number of Residents per Day Footnote	Affiliated Entity Na	Affiliated Entity ID	Continuing Care Retirement Commun	Special Focus Sta	Abuse Ico	Most Recent Health Inspection More Than 2 Years Ago	Provider Changed Ownership in Last 12 Months
THE EMERALD PEEK REHABILITATION AND NURSING CENTER	PEEKSKILL	Westchester	No	For profit	100	82		CARERITE CEN	110	N		N	Y	N
AUBURN REHABILITATION & NURSING CENTER	AUBURN	Cayuga	Yes	For profit	92	83.8		PERSONAL HE	398	N		N	N	N
BRIARCLIFF MANOR CENTER FOR REHAB AND NURSING CARE	BRIARCLIFF M	Westchester	Yes	For profit	131	110.4		EXCELSIOR CA	217	N		N	Y	N
KATHERINE LUTHER RESIDENTIAL HLTH CARE & REHAB	CLINTON	Oneida	Yes	Non profit	280	101.8				N		N	Y	N
ST JOHNS HEALTH CARE CORPORATION	ROCHESTER	Monroe	Yes	Non profit	455	298				N		N	N	N
ST PATRICKS HOME	BRONX	Bronx	No	Non profit	264	255.9				N		N	Y	N
SCHENECTADY CENTER FOR REHABILITATION AND NURSING	SCHENECTADY	Schenectady	No	For profit	240	235.8		CENTERS HEAI	127	N		N	N	N
SCHERVIER NURSING CARE CENTER	BRONX	Bronx	Yes	For profit	366	347				N		N	N	N
BEECHTREE CENTER FOR REHABILITATION AND NURSING	ITHACA	Tompkins	Yes	For profit	120	114.4		UPSTATE SERV	538	N		N	N	N
REGEIS CARE CENTER	BRONX	Bronx	No	For profit	236	220.6				N		N	N	N
HEBREW HOME FOR THE AGED AT RIVERDALE	RIVERDALE	Bronx	No	Non profit	843	502.2				N		N	N	N
SANDS POINT CENTER FOR HEALTH AND REHABILITATION	PORT WASHIN	Nassau	No	For profit	180	161.5		NATIONAL HE	363	N		N	N	N
A HOLLY PATTERSON EXTENDED CARE FACILITY	UNIONDALE	Nassau	Yes	Government	589	489.2				N	SFF Candidate	N	Y	N
BEACH TERRACE CARE CENTER	LONG BEACH	Nassau	No	For profit	182	175				N		N	N	N
WEST VILLAGE REHABILITATION AND NURSING CENTER	NEW YORK	New York	No	Non profit	105	96.6				N		N	N	N
THE CITADEL REHAB AND NURSING CTR AT KINGSBRIDGE	BRONX	Bronx	No	For profit	400	348.9		CITADEL CARE	146	N		N	Y	N
MOSHOLU PARKWAY NURSING & REHABILITATION CENTER	BRONX	Bronx	No	For profit	122	119.1				N		N	N	N
WYOMING COUNTY COMMUNITY HOSPITAL S N F	WARSAW	Wyoming	No	Government	138	134.8				N		N	N	N
HILAIRE REHAB & NURSING	HUNTINGTON	Suffolk	No	For profit	76	71.5				N		N	N	N
FAR ROCKAWAY CENTER FOR REHABILITATION AND NURSING	FAR ROCKAW	Queens	Yes	For profit	100	95.5				N		N	N	N
NORTHERN MANOR GERIATRIC CENTER INC	NANUET	Rockland	Yes	Non profit	231	218.7				N		N	N	N
WILLIAMSBRIDGE CENTER FOR REHABILITATION AND NRSG	BRONX	Bronx	No	For profit	77	74.7		ALLURE GROU	24	N		N	Y	N
MARY MANNING WALSH NURSING HOME CO INC	NEW YORK	New York	No	Non profit	362	338.1		ARCHCARE	43	N		N	Y	N
ELCOR NURSING AND REHABILITATION CENTER	HORSEHEADS	Chemung	No	For profit	305	255.1				N		N	N	N
ELDERWOOD AT AMHERST	AMHERST	Erie	Yes	For profit	92	85.2		ELDERWOOD	196	N		N	N	N
UNIVERSITY CENTER FOR REHABILITATION AND NURSING	BRONX	Bronx	No	For profit	46	44.3		CENTER MANA	619	N		N	N	N
COLER REHABILITATION AND NURSING CARE CENTER	ROOSEVELT IS	New York	No	Government	815	495		NEW YORK CI	368	N		N	N	N
APEX REHABILITATION & CARE CENTER	HUNTINGTON	Suffolk	No	For profit	195	193				N		N	Y	N
CROUSE COMMUNITY CENTER INC	MORRISVILLE	Madison	No	Non profit	120	106.3				N		N	N	N
CONESUS LAKE NURSING HOME	LIVONIA	Livingston	No	For profit	48	41.8		HURLBUT CAF	275	N		N	N	N
BROOKLYN GARDENS NURSING & REHABILITATION CENTER	BROOKLYN	Kings	Yes	Non profit	240	221.1				N		N	N	N
ST JOSEPH'S HOSPITAL - SKILLED NURSING FACILITY	ELMIRA	Chemung	Yes	Non profit	85	72.5				N		N	Y	N
PARKVIEW CARE AND REHABILITATION CENTER, INC	MASSAPEQUA	Nassau	No	For profit	169	142		BENJAMIN LA	646	N		N	N	N
NORTHWOODS REHAB AND NURSING CENTER AT MORAVIA	MORAVIA	Cayuga	No	For profit	40	34.7		STERN CONSU	661	N		N	N	N
YORKTOWN REHABILITATION & NURSING CENTER	CORTLANDT M	Westchester	No	For profit	200	105.7		PERSONAL HE	398	N		N	Y	N
GOLD CREST CARE CENTER	BRONX	Bronx	No	For profit	175	169.8		MAYER FAMIL	340	N		N	N	N
HUDSON HILL CENTER FOR REHABILITATION & NURSING	YONKERS	Westchester	Yes	For profit	315	234.7		INFINITE CARE	578	N		N	N	N
ST ANNS COMMUNITY	ROCHESTER	Monroe	No	Non profit	470	366.6				N		N	N	N
WATERVIEW HEIGHTS REHABILITATION AND NURSING CTR	ROCHESTER	Monroe	Yes	For profit	229	190.5		HURLBUT CAF	275	N	SFF	N	N	N
BERKSHIRE NURSING & REHABILITATION CENTER	WEST BABYLO	Suffolk	No	For profit	175	165.1				N		N	N	N

Provider Data

- LTCCC's Provider data files are updated semi-annually from the CMS database.
- The included data are put into searchable/sortable files.
- They include:
  - Name
  - Number
  - Ownership type
  - Affiliated entity name (if any)
  - Abuse icon
  - Special Focus Facility
  - Most recent inspection more than two years
  - Provider changed ownership in last year
  - CMS ratings
  - Reported and case-mix adjusted staffing
  - Ratings over last three cycles
  - Citations & fines
  - Substantiated complaints

https://nursinghome411.org/data/ratings-info/

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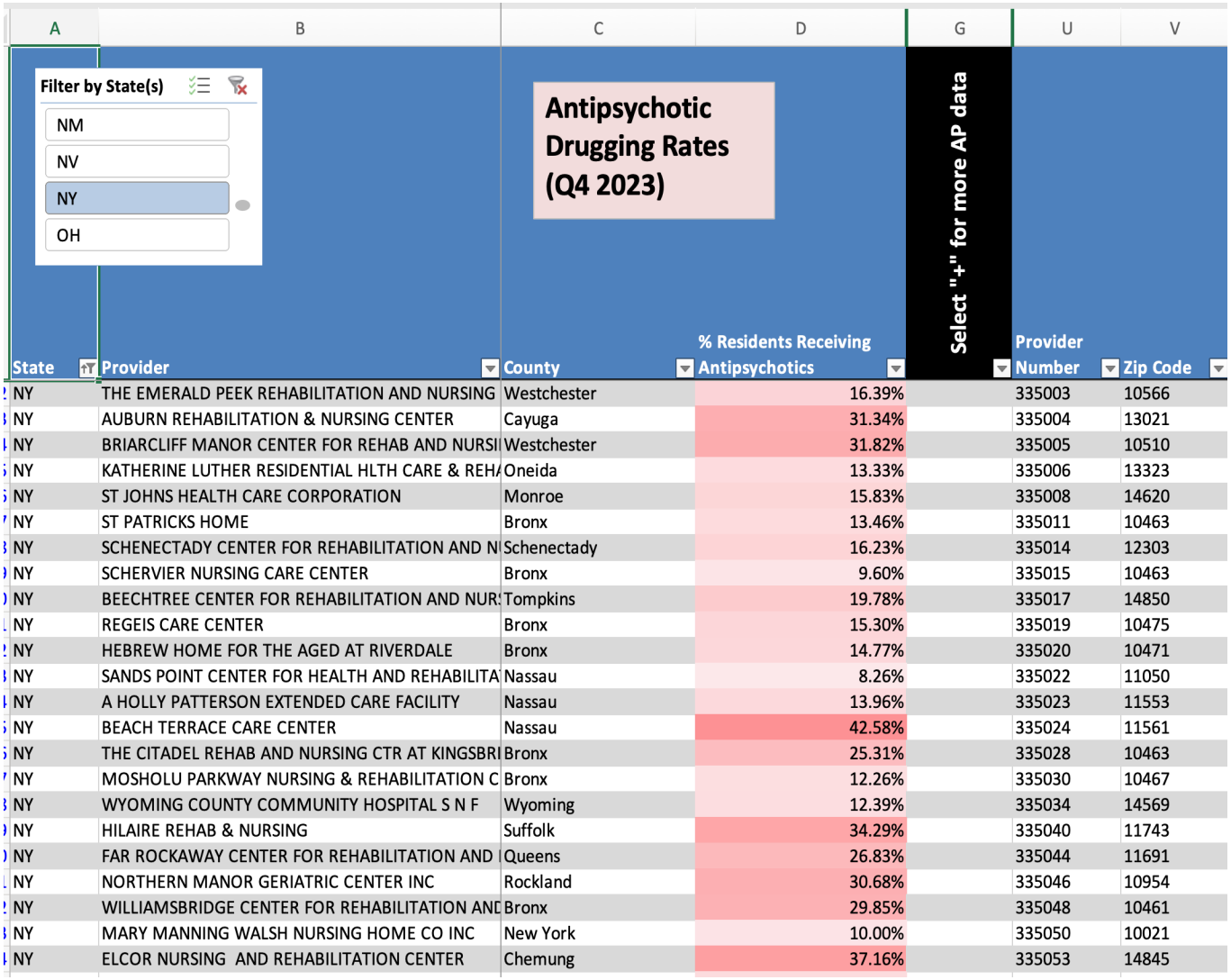
Nursing Home Data Updates

Antipsychotic Drugging Rates

Antipsychotic Drugging Rates



Filter by State(s)

NM
NV
NY
OH

Antipsychotic Drugging Rates (Q4 2023)

Select "+" for more AP data

State	Provider	County	% Residents Receiving Antipsychotics	Provider Number	Zip Code
NY	THE EMERALD PEEK REHABILITATION AND NURSING	Westchester	16.39%	335003	10566
NY	AUBURN REHABILITATION & NURSING CENTER	Cayuga	31.34%	335004	13021
NY	BRIARCLIFF MANOR CENTER FOR REHAB AND NURSI	Westchester	31.82%	335005	10510
NY	KATHERINE LUTHER RESIDENTIAL HLTH CARE & REHA	Oneida	13.33%	335006	13323
NY	ST JOHNS HEALTH CARE CORPORATION	Monroe	15.83%	335008	14620
NY	ST PATRICKS HOME	Bronx	13.46%	335011	10463
NY	SCHENECTADY CENTER FOR REHABILITATION AND N	Schenectady	16.23%	335014	12303
NY	SCHERVIER NURSING CARE CENTER	Bronx	9.60%	335015	10463
NY	BEECHTREE CENTER FOR REHABILITATION AND NUR	Tompkins	19.78%	335017	14850
NY	REGEIS CARE CENTER	Bronx	15.30%	335019	10475
NY	HEBREW HOME FOR THE AGED AT RIVERDALE	Bronx	14.77%	335020	10471
NY	SANDS POINT CENTER FOR HEALTH AND REHABILITA	Nassau	8.26%	335022	11050
NY	A HOLLY PATTERSON EXTENDED CARE FACILITY	Nassau	13.96%	335023	11553
NY	BEACH TERRACE CARE CENTER	Nassau	42.58%	335024	11561
NY	THE CITADEL REHAB AND NURSING CTR AT KINGSBRI	Bronx	25.31%	335028	10463
NY	MOSHOLU PARKWAY NURSING & REHABILITATION C	Bronx	12.26%	335030	10467
NY	WYOMING COUNTY COMMUNITY HOSPITAL S N F	Wyoming	12.39%	335034	14569
NY	HILAIRE REHAB & NURSING	Suffolk	34.29%	335040	11743
NY	FAR ROCKAWAY CENTER FOR REHABILITATION AND	Queens	26.83%	335044	11691
NY	NORTHERN MANOR GERIATRIC CENTER INC	Rockland	30.68%	335046	10954
NY	WILLIAMSBRIDGE CENTER FOR REHABILITATION AND	Bronx	29.85%	335048	10461
NY	MARY MANNING WALSH NURSING HOME CO INC	New York	10.00%	335050	10021
NY	ELCOR NURSING AND REHABILITATION CENTER	Chemung	37.16%	335053	14845

https://nursinghome411.org/data/ap-drugs/

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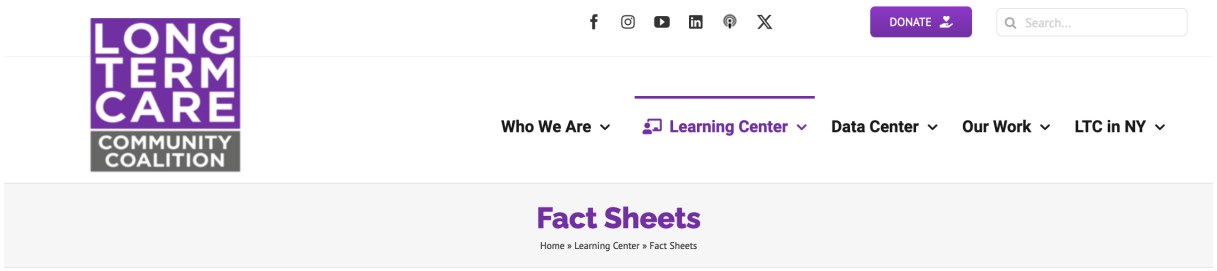
Additional Resources @

www.nursinghome411.org

Free Fact Sheets on Resident Rights



LTCCC Fact Sheets provide brief summaries of relevant standards and tips on how the standards can be used to support better care and quality of life.

We welcome you to use, copy and adapt these materials in your efforts to improve care. For basic information on selected resident care concerns, please visit our **Handouts** page. For more in-depth information, please see our **Issue Alerts** or our **Reports** pages.

- Abuse, Neglect & Exploitation
- Abuse & Neglect in Assisted Living
- Activities Staff Role
- Administrators' Role
- Admission & Discharge Rights in NY State Nursing Homes
- Antipsychotic Drugging
- Bed Rails
- Behavioral & Social Health Services
- Dementia Care & Antipsychotic Drug Basics
- Dementia Care & Psychotropic Drugs
- Dementia Care Considerations
- Dementia Care Practices
- Fall & Accident Prevention
- Food, Nutrition, and Dietary Services
- Foundations of Resident Rights
- Immediate Access to Nursing Home Residents
- Infection Prevention and Control
- Informed Consent
- Introduction to the Dementia Care Toolkit
- Medicare Coverage of Skilled Nursing & Skilled Therapy Services
- Medical Directors' Role
- Medication Errors
- Non-Pharmacological Approaches to Dementia Care
- Nurse Aide Training Requirements
- Nursing Home Therapy Services (PT, OT, etc.)
- Ownership in Assisted Living
- Pain Management
- Pharmacy Services
- Pre-Dispute Arbitration
- Pressure Ulcers
- Providing Input on Facility Assessments
- Quality Assurance & Performance Improvement (QAPI)
- Registered Nurse Requirements in Assisted Living
- Requirements for Nursing Home Care Staff & Administration
- Requirements for Nursing Home Physician, Rehab & Dental Services
- Resident & Family Councils
- Resident & Family Record-Keeping
- Resident Assessment & Care Planning
- Resident Care Planning
- Resident Dignity & Quality of Life Standards
- Resident Grievances & Complaints
- Resident-Centered Advocacy When a Nursing Home is Cited for Substandard Care, Abuse or Neglect
- Resident Rights to Dignity & Respect
- Safe Environment
- Social Workers' Role
- Staffing Ratios in Assisted Living
- Staff Training & Competency in Assisted Living
- Standards for Nursing Home Services
- Standards for People Providing Resident Care
- Standards of Care for Resident Well-Being
- Survey Reports in Assisted Living
- Third Party Guarantee
- Transfer & Discharge Rights
- Transfer & Discharge Rights II

Family Empowerment Resource Center

Family Council Empowerment Resources

When families and friends of nursing home residents join together, they can be a powerful force for improving care and ensuring dignity. LTCCC, a nonprofit organization dedicated to improving nursing home care, provides a range of resources and tools to support resident-centered advocacy. This page includes a family council toolkit and other resources for residents, families, and those who work with them. All of our materials are free to use and share.

Download Family Council Toolkit

*Click here for two-sided printing option.

A Note to Families

Family councils can make a real difference in the lives of nursing home residents. Here's how.

Read more ›

Free Meeting Rooms

Host free online family council meetings (unlimited time) for in the NursingHome411 Zoom Room.

Sign up ›

Empowerment Programs

Watch our programs about issues impacting families of nursing home residents.

Family Empowerment Programs ›

Resources for Families

Family Empowerment Programs
Family & Ombudsman Resource Center
Fact Sheet: Resident and Family Councils
Tips for Cold Season
Tips for Compassion Fatigue
Tips for Privacy and Independence
Tips For Providing Input on Your Nursing Home's Staffing Assessment

Family Council Brochure
Forms & Tools for Advocacy
LTCCC Webinars
LTCCC Data Center
Resident Rights Fact Sheet Center
LTCCC Learning Center
Video: How Do I Start a Family Council?
Voting Resources

Find Your Legislators
Info & Contacts for Reporting Abuse or Neglect
Recursos en Español (Resources in Spanish)
Resous nan Kreyòl Ayisyen (Resources in Haitian Creole)
中文资源 (Resources in Chinese)
한국어 자료 (Resources in Korean)

Nursing Home Abuse, Neglect, & Crime Reporting Center

LONG TERM CARE COMMUNITY COALITION

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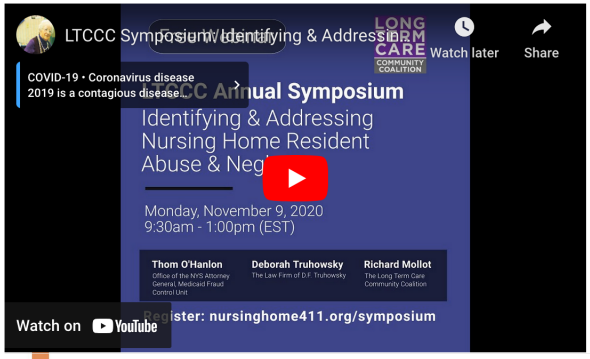
Abuse, Neglect, and Crime Reporting Center

Home » Learning Center » Abuse, Neglect, and Crime Reporting Center

Residents in nursing homes are typically frail. The majority are senior citizens, and many have dementia. By definition, they all need 24-hour a day skilled nursing services. Nevertheless, though they live in an institutional setting, it is crucial to keep in mind that residents retain all of the rights of people who live outside of a facility. This includes the right to live free of physical, emotional, verbal, and sexual abuse and the right to be treated with dignity. It also includes the right to have the same access to criminal justice as anyone living in the outside community.

Unfortunately, too often, when individuals go into a nursing home, society views them as having entered a separate world, where different rules apply. This is not true. To strengthen realization of vital protections for seniors in nursing homes, LTCCC undertook **a study to identify promising practices** that have been employed in different communities to address elder abuse, neglect, and crime in residential settings.

This pages features a selection of resources that are free to use, share, and adapt. We also recommend viewing **LTCCC's 2020 Symposium on identifying and addressing resident abuse and neglect**.



LTCCC SYMPOSIUM: IDENTIFYING & ADDRESSING ABUSE & NEGLECT

- ADDRESSING ABUSE, NEGLECT, AND SUSPICION OF CRIME AGAINST NURSING HOME RESIDENTS
- FEDERAL CONTACTS FOR FILING A COMPLAINT
- LINK TO STATE AGENCY CONTACTS & COMPLAINT FORMS
- LINK TO STATE MEDICAID FRAUD CONTROL UNITS
- DEFINITIONS OF NURSING HOME ABUSE, NEGLECT, & CRIME
- FORM FOR INVESTIGATING RESIDENT INJURIES OR SUSPICION OF CRIME
- FORMS & TOOLS FOR RESIDENT-CENTERED ADVOCACY
- MEMO FOR LAW ENFORCEMENT ON NURSING HOME ABUSE & NEGLECT
- UNDERSTANDING BODILY INJURY WHEN REPORTING SUSPICION OF A CRIME AGAINST A NURSING HOME RESIDENT