

2001

Long-Term Care under Fire: A Case for Rational Enforcement

Jennifer Gimler Brady

Follow this and additional works at: <https://scholarship.law.edu/jchlp>

Recommended Citation

Jennifer G. Brady, *Long-Term Care under Fire: A Case for Rational Enforcement*, 18 J. Contemp. Health L. & Pol'y 1 (2002).

Available at: <https://scholarship.law.edu/jchlp/vol18/iss1/3>

This Article is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Journal of Contemporary Health Law & Policy (1985-2015) by an authorized editor of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

ARTICLES

LONG-TERM CARE UNDER FIRE: A CASE FOR RATIONAL ENFORCEMENT

*Jennifer Gimler Brady**

Despite reforms to ensure that nursing homes maintain compliance with federal quality standards, one-fourth of all homes nationwide continue to be cited for deficiencies that either caused actual harm to residents or carried the potential for death or serious injury. This pattern has not changed since the July 1995 reforms were implemented. *Although the reforms equipped federal and state regulators with many alternatives and tools to help promote sustained compliance with Medicare and Medicaid standards, the way in which states and HCFA have applied them appears to have resulted in little headway against the pattern of serious and repeated noncompliance.* Such performance may do little to dispel concerns over the health and safety of frail and dependent nursing home residents.¹

INTRODUCTION

The staggering statistics highlight the need to ensure nursing home compliance with federal quality standards. In 1997, individuals aged sixty-five and over comprised approximately thirteen percent of the total population in the United States; by 2030, that number will increase to

* Partner, Potter, Anderson & Corroon, LLP; LL.M. Health Law 2000, Widener University School of Law; J.D. 1990, Dickinson School of Law; B.A. 1987, College of William and Mary. The author would like to acknowledge Dean Barry Furrow of the Widener University School of Law for his guidance and assistance, and her husband Bob for his support and humor.

1. U.S. GEN. ACCOUNTING OFFICE REPORT TO THE U.S. SENATE SPECIAL COMM. ON AGING, NURSING HOMES: ADDITIONAL STEPS NEEDED TO STRENGTHEN ENFORCEMENT OF FED. QUALITY STANDARDS 22 (1999) [hereinafter QUALITY STANDARDS REPORT] (emphasis added), available at <http://www.gao.gov/archive/1999/he99046.pdf>.

twenty percent.² From 1997 to 2030, the number of individuals eighty-five years of age and older, the group most likely to require long-term care services,³ will more than double from approximately 3.9 million people to approximately 8.5 million people.⁴ By 2050, the segment of the population eighty-five and over will double again.⁵ The aging baby boom generation, consisting of approximately seventy-six million people born between 1946 and 1964, is expected to generate an unprecedented demand for long-term care services.⁶ Thus, it is essential that the long-term care industry be prepared adequately to meet the increasing demand.

Nursing home care is an important long-term care service. Every year, more than 1.5 million people are admitted to the seventeen thousand nursing homes throughout the United States.⁷ These nursing homes provide intermediate and skilled nursing care to individuals who are too ill to be adequately cared for in a home setting, but not so ill that they require hospitalization. Because nursing homes provide care to this vulnerable group of people, overwhelmingly consisting of elderly, frail,

2. *Long-Term Care: Baby Boom Generation Presents Financing Challenges, Testimony Before the Senate Special Comm. on Aging*, 105th Cong. 4-5 (1998) [hereinafter referred to as *Panel Report*] (statement of William J. Scanlon, Director, Health Financing and Systems Issues, Health, Education, and Human Services Div., GAO) (citing U.S. BUREAU OF THE CENSUS, RESIDENT POPULATION OF THE UNITED STATES: ESTIMATES, BY AGE AND SEX (1998); U.S. BUREAU OF THE CENSUS, RESIDENT POPULATION OF THE UNITED STATES: MIDDLE SERIES PROJECTIONS, 2015 TO 2030, BY AGE AND SEX (1996); and U.S. BUREAU OF THE CENSUS, RESIDENT POPULATION OF THE UNITED STATES: MIDDLE SERIES PROJECTIONS, 2035 TO 2050, BY AGE AND SEX (1996)), available at <http://www.gao.gov/archive/1998/he98107t.pdf> [hereinafter Scanlon Statement].

3. *Id.* The term “long-term care,” as used herein, encompasses a variety of health care, personal care, and supportive services that are needed by individuals who, due to illness or chronic conditions, are unable to adequately care for themselves. Nursing homes, the focus of this article, are just one form of long-term care; other forms include, but are not limited to, assisted living, home care and day programs.

4. See Scanlon Statement, *supra* note 2, at 4.

5. *Id.*

6. *Id.*

7. U.S. GEN. ACCOUNTING REPORT TO THE U.S. SENATE SPECIAL COMM. ON AGING, CALIFORNIA NURSING HOMES: CARE PROBLEMS PERSIST DESPITE FED. AND STATE OVERSIGHT 3 (1998), [hereinafter CALIFORNIA REPORT] available at <http://www.gao.gov/archive/1998/he98202.pdf> 9

chronically ill and often mentally limited individuals, it is not surprising that nursing homes are one of the most scrutinized and heavily regulated businesses in the United States. Indeed, as explained below, nursing homes are subject to an increasingly complex web of federal and state regulation and oversight.

It is beyond dispute that an appropriate degree of regulation and oversight serves the laudable purpose of ensuring that nursing home residents receive quality care in a nurturing, healthful environment. However, at the present time, the effectiveness of governmental regulation and oversight is being debated with an intensity that has not been witnessed since the passage of the comprehensive nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987, also known as the Nursing Home Reform Act.⁸ At the forefront of the debate are savvy federal and state legislators who play on the fears of the politically powerful baby boom generation and pander for support by advocating a “get tough on the nursing home industry” platform. One need only consider a sampling of nursing home horror stories recounted in the popular press to get a sense of the tenor of the debate. These stories are replete with examples of neglect, or worse, intentional abuse, and the nursing home industry is portrayed as thumbing its collective nose at federal and state regulators, with bottom line-oriented nursing home administrators making an unabashed grab for cash at the expense of quality care.⁹

8. Omnibus Budget Reconciliation Act of 1987 42 U.S.C. §§ 1395i-1396r (1994) [hereinafter OBRA 87].

9. See, e.g., Steve Bates, *Nursing Home Horrors*, 42 AARP BULL. 9, Sept. 1999, at 9 (“Previous studies have found that one in four of the nation’s nearly 17,000 nursing homes have serious deficiencies that harm residents or threaten their lives.”); Kym Liebler, *Nursing Homes are Targeted*, NEWS J. (Del.), July 24, 1998, at B1 (quoting Senator Robert Marshall, D-Wilmington West, “We [Delaware] had over 1,000 reported accidents leading to more serious injuries. It’s a sad commentary on society, the lack of accountability. We have had a tendency to ignore within the institutional culture of nursing home facilities the quality of daily care given to senior citizens, or others living there.”); *Nursing Home Care Declining in Maryland*, NEWS J. (Del.), Jan. 10, 2000, at B6 (citing a sharp rise in substandard care complaints since 1998); Mark Thompson, *Fatal Neglect in Possibly Thousands of Cases, Nursing Home Residents are Dying From a Lack of Food and Water and the Most Basic Level of Hygiene*, TIME, Oct. 27, 1997; *Victims of Greed*, (ABC television broadcast, Oct. 25, 1991) (exposing patient abuse and neglect in Texas nursing homes; the owners of the featured nursing homes filed a

It should not come as a surprise that the anti-nursing home platform is striking a chord with its intended audience. Regulators and citizens alike are demanding increased scrutiny of nursing home operations, as well as the imposition of significant penalties on nursing homes that are found to provide substandard care. While both of these actions appear reasonable, the nursing home industry is reeling from the manner in which these goals are being pursued. Indeed, the industry is finding itself marginalized, as regulators are shifting from an enforcement regime—marked by cooperation and the shared goal of improving the quality of care—to a policy focused solely on punishing any deficiency, without consideration of any mitigating factors. The nursing home industry is again on the defensive, fearful that the current debate over quality of care issues and enforcement will result in yet another layer of costly and burdensome regulation. Even more problematic, this debate is coming at a time when reimbursement rates are being slashed and once-stable nursing home operations are filing for bankruptcy protection in record numbers.¹⁰ The industry's fears are well founded. In recent years, several new enforcement initiatives have been implemented at both the federal and state level, and many more are under consideration.¹¹ One must question the wisdom of imposing another layer of regulation on an industry that already is overwhelmed by federal and state mandates. Indeed, as the introductory quotation aptly recognizes, to the extent that there are problems with the quality of care provided by certain nursing homes, those problems do not exist because of a lack of regulation. Rather, regulators' efforts would be better spent looking inward to evaluate and improve the quality of their regulatory enforcement mechanisms.

Compounding the nursing home industry's current troubles is a dramatic upswing in litigation aimed at the quality of care provided by nursing homes.¹² Previously the characteristics of the typical nursing

defamation action against ABC, but summary judgment was granted in favor of ABC).

10. Douglas Hanks III, *Nursing Homes: Condition Critical*, NEWS J. (Del.), Apr. 3, 2000, at D8. See also, Nathan Childs, *How Will Long Term Care Remember the Clinton Years*, PROVIDER, Nov. 1999, at 33.

11. See HEALTH CARE FINANCING ADMIN., INNOVATIVE STATE AND HCFA NURSING HOME INITIATIVES, at <http://www.hcfa.gov/medicaid/nhi/nhidiscl.htm> (June 7, 2001). See generally Elaine C. Zacharakis, *Increased Federal Enforcement of Nursing Homes Expected*, HEALTH L., July 1999, at 12.

12. See Markian Hawryluk, *Navigating Through a Legal Storm*, PROVIDER,

home patient—advanced age, compromised physical condition, and quite possibly, mental impairment—discouraged lawsuits for injuries allegedly resulting from poor care.¹³ Today, however, the lure of enormous punitive damage awards has changed the playing field. For example, in November 1997, a Texas jury awarded \$83 million to the family of an eighty-four year old nursing home resident who died from dehydration and infected pressure sores.¹⁴ Also, in March 1998, a California jury awarded \$94.7 million to a resident who suffered a broken hip and shoulder while being transferred from her bed.¹⁵ Over the past decade, both the number and costs of claims against nursing homes have risen significantly.¹⁶ According to St. Paul Fire and Marine Insurance Company, a medical professional liability insurer that insures long-term care providers throughout the country, the company closed approximately 2,500 claims against nursing facilities from 1988 to 1992.¹⁷ During the period from 1993 to 1997, the number of claims soared to more than 4,200.¹⁸ Furthermore, from 1988 to 1992, only one claim exceeded \$500,000, while during the period from 1993 to 1997, thirty-two claims over \$500,000 were paid by the company, including six claims that exceeded \$1 million.¹⁹ These statistics strongly

Apr. 1999, at 26.

13. See BARRY R. FURROW ET AL., HEALTH LAW CASES, MATERIALS AND PROBLEMS 113 (3rd ed. 1997):

The characteristics of the nursing home population have limited their ability to bring suit for harms suffered as a result of poor care or abuse. Causation may be difficult to prove. Physical injuries in very frail elderly persons may be caused either by ordinary touching or by poor care or abuse. Mental impairment makes many nursing home residents poor witnesses. Limited remaining life spans and disabilities minimize legally recognizable damages. They do not suffer lost wages and costs of medical care for injuries for the majority of patients will be covered by Medicaid or Medicare.

Id.

14. Hawryluk, *supra* note 12, at 26.

15. See Gregory v. Beverly Enterprises, 80 Cal. App. 4th 514 (2000); See Hawryluk, *supra* note 12, at 26. The court subsequently reduced the punitive damage award to \$3.1 million. See also *California Judge Cuts Beverly Enterprises Verdict to \$3.1 Million*, WALL ST. J., June 10, 1998, at B8.

16. Hawryluk, *supra* note 12, at 29.

17. *Id.*

18. *Id.*

19. *Id.*

suggest that the nursing home industry may be poised to follow in the footsteps of asbestos and tobacco as the next target of the plaintiffs' bar, with disastrous consequences for the industry.

This article examines some of the significant challenges currently facing the nursing home industry in the United States. It begins with a review of the history of nursing home regulation, with a particular focus on the comprehensive nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987. It then explores the new environment in which the nation's seventeen thousand nursing homes are operating, including recent federal initiatives aimed at the nursing home industry. This article also discusses the Delaware General Assembly's recent revamping of the entire nursing home oversight structure in the state, as it serves as an informative example of the excessive regulation that distinguishes the nursing home industry. In addition, the article examines the disastrous impact of the Balanced Budget Act of 1997 on the financial stability of the nursing home industry. Next, it considers the upswing in private litigation against nursing homes and its effectiveness as a deterrent to inadequate care. Finally, the article concludes with recommendations for addressing concerns about the nation's nursing home industry without resorting to additional mandates that ultimately will prove to be unduly burdensome, costly, and ineffective as a means of assuring that nursing home residents receive high quality care.

I. THE HISTORY OF NURSING HOME REGULATION

A. *Medicare and Medicaid*

Prior to the enactment of Medicaid and Medicare in 1965, oversight of the nursing home industry was largely the responsibility of the individual states, with some federal guidance.²⁰ With Medicaid and Medicare came a dramatic increase in federal funding of nursing homes, and the United States Department of Health, Education and Welfare established health and safety standards for nursing homes that wished to participate in

20. Hollis Turham, National Long Term Care Ombudsman Resource Center, *Federal Nursing Home Reform Act from the Omnibus Budget Reconciliation Act of 1987 or Simply OBRA '87 Summary*, at http://www.ltombudsman.org/ombpublic/49_346_1023.cfm (last visited Dec. 18, 2001).

federally funded programs.²¹ However, the standards proved to be so taxing that only 740 of the 6,000 nursing home applicants seeking participation could be fully certified.²² Thus, at that time, the government abandoned the idea of using federal nursing home licensing standards, and it left the responsibility to the states to decide if nursing homes qualified for participation in Medicare and Medicaid.²³

In the 1970s, a highly publicized class action lawsuit, *Smith v. O'Halloran*,²⁴ caused the federal government to revisit the area of nursing home regulation. The class action plaintiffs, who were young, severely-disabled nursing home residents, sued the nursing home owners as well as the federal government.²⁵ In the lawsuit, the plaintiffs challenged the quality of care provided by the Colorado nursing home and alleged that their rights had been violated.²⁶ In addition, the plaintiffs claimed the government had failed to sufficiently monitor nursing homes to ensure that residents receive adequate care.²⁷

In 1980, while the class action litigation was proceeding, the Health Care Financing Administration (HCFA),²⁸ an agency of the United States Department of Health and Human Services, attempted to revise the federal nursing home regulations regarding the process by which nursing homes are certified for Medicare and Medicaid eligibility.²⁹ HCFA's intention was to shift the focus of the certification regulations from paper reviews, designed to evaluate a facility's capability to provide care, to an assessment of the care actually received by patients.³⁰ However, these regulations were rescinded by the newly-installed Reagan Administration,

21. COMM. ON NURSING HOME REGULATION, INST. OF MED., NAT'L ACAD. OF SCIENCES, IMPROVING THE QUALITY OF CARE IN NURSING HOMES 241 (1986) [hereinafter IOM REPORT].

22. *See id.*

23. *See id.* at 242.

24. *Smith v. O'Halloran*, 557 F. Supp. 289 (D. Colo. 1983), *rev'd sub nom. Smith v. Heckler*, 747 F.2d 583 (10th Cir. 1984).

25. *Id.* at 290.

26. *Id.*

27. *Id.*

28. The Bush Administration on June 14, 2001 changed the Health Care Financing Administration, HCFA, to the Centers for Medicare and Medicaid Services (CMS).

29. IOM REPORT, *supra* note 21, at 247.

30. *See id.*

which wanted to create its own regulatory reform effort.³¹

In 1982, HCFA announced regulatory changes to address providers' complaints about certain requirements being unreasonably rigid.³² The proposed regulations would have eased the annual inspection and certification process for facilities with a solid history of compliance.³³ They also would have allowed states to accept accreditation by the Joint Commission on Accreditation of Hospitals in lieu of state inspection as a basis for certifying compliance with federal participation requirements.³⁴ However, HCFA's proposed regulations were not implemented, primarily due to the fact that they were strongly opposed by consumer groups and most state regulatory agencies, who viewed the regulations as being too lenient and industry-oriented.³⁵ Thereafter, on the heels of several failed attempts to pass new regulations, HCFA contracted with the Institute of Medicine (IOM) of the National Academy of Sciences to engage in a study "that would serve as a basis for adjusting federal (and state) policies and regulations governing the certification of nursing homes so as to make those policies and regulations as appropriate and effective as possible."³⁶

Coincidentally, at the time, the *Smith* Court determined that Medicaid law imposes a duty upon the Secretary of Health and Human Services to "establish a system to adequately inform herself as to whether the facilities receiving federal money are satisfying the requirements of the [Medicaid] Act . . . including providing high quality patient care."³⁷ The court ordered the Secretary to draft regulations to ensure that nursing homes provide competent patient care, including the use of survey forms, guidelines, and procedures.³⁸

In 1986, the IOM released its report entitled, "Improving the Quality of Care in Nursing Homes" (IOM Report). The IOM Report identified serious problems in both the quality of care provided to nursing home residents, as well as the overall quality of life of residents.³⁹ With respect

31. *See id.*

32. *See id.* at 1.

33. *Id.*

34. *See id.* at 1-2.

35. *Id.* at 2.

36. *Id.*

37. *Smith v. Heckler*, 747 F.2d at 583, 589 (10th Cir. 1984).

38. *See id.* at 587.

39. IOM REPORT, *supra* note 21, at 21.

to the quality of care, the IOM Report observed that:

Providing consistently high quality care in nursing homes to a varied group of frail, very old residents, many of whom have mental impairments as well as physical disabilities, requires that the functional, medical, social, and psychological needs of residents be individually determined and met by careful assessment and care planning – steps that require professional skill and judgment. . . . To hold down costs, most of the care is provided by nurse’s aides who, in many nursing homes, are paid very little, receive relatively little training, are inadequately supervised, and are required to care for more residents than they can serve properly. Not surprisingly, the turnover rate of nurse’s aides is usually very high – from 70 percent to over 100 percent per year – a factor that causes stress in resident-staff interactions.⁴⁰

The IOM Report concluded that the quality of staff-resident relationships largely controls the quality of life that residents experience in nursing homes, noting that “kindness, courtesy, and opportunities to choose activities, food, and mealtimes are involved, as are factors such as privacy for intimate conversations with family and friends.”⁴¹ Significantly, the IOM found that while there were a number of “good” nursing homes that provide quality care and respect the dignity and privacy of residents, “the Committee has the impression, obtained primarily from [HCFA’s] data collected from state reports on nursing home deficiencies, and from discussions with knowledgeable state and federal regulatory agency personnel, that the poor-quality homes outnumber the very good homes.”⁴²

The conclusions reached by the IOM were neither novel nor unexpected. Of greater interest were the IOM’s recommendations for improving the quality of care and the quality of life in the nation’s nursing homes. Specifically, the IOM recommended:

- (1) revising the existing conditions that nursing homes must satisfy to participate in the Medicare and Medicaid programs (also referred to herein as “conditions of participation” or “participation standards”) and adding new conditions where

40. *Id.* at 10-11.

41. *Id.* at 11.

42. *Id.*

appropriate;⁴³

(2) strengthening the process by which nursing homes are monitored for compliance with the conditions of participation;⁴⁴

(3) implementing stronger sanctions for noncompliance with the conditions of participation;⁴⁵ and

(4) enhancing the effectiveness of consumers and consumer advocates in quality assurance oversight.⁴⁶

The IOM recognized that accomplishing these goals would require significant governmental and financial resources. However, the IOM also noted that increased regulation alone cannot guarantee quality of life in nursing homes. Despite the fact that one of the primary mandates to the IOM was to formulate recommendations for an entirely new regulatory framework for the nursing home industry, the IOM acknowledged the practical limitations of enforcement standards, observing that:

[t]hree other factors are important [in ensuring quality care in nursing homes]: (1) active consumer involvement and effective consumer advocacy; (2) active community interest and involvement in nursing homes, and (3) positive motivation on the part of the owners and managers of nursing homes, and well-trained, well-supervised, and properly motivated staff. The first two are needed to help improve quality of life for residents and influence the attitudes and performance of the government regulators and elected officials as well as the attitudes and behavior of the management and staff of nursing homes. The third is essential for high-quality care. *Pressures by regulators and consumers certainly can influence management and staff attitudes and behavior, but such pressures are not sufficient to attract the quality of personnel needed to provide high quality of care and quality of life to nursing home residents. The desire for excellent performance and the ability to create the climate that will attract highly motivated and well-qualified professionals to work in nursing homes must be nurtured by sources within the industry and the educational and professional institutions that train and foster professional values, attitudes, and ethical standards.*⁴⁷

43. See *id.* at 25-32.

44. See *id.* at 32-38.

45. See *id.* at 38-40.

46. See *id.* at 41-42.

47. *Id.* at 171-72 (emphasis added).

Still, the significance of the IOM's work lies in its recommendations, which served as the foundation for a complete overhaul of the processes by which nursing homes are surveyed for compliance with participation standards and sanctioned when they fall short of those standards.

B. *The Omnibus Budget Reconciliation Act of 1987*

Based in large part upon the conclusions and recommendations set forth in the IOM Report, in 1987 Congress passed sweeping legislation aimed at monitoring and regulating the nursing home industry in the United States. The legislation, the Omnibus Budget Reconciliation Act of 1987 (OBRA 87),⁴⁸ changed the way that states and the federal government oversee nursing homes and protect the well-being of nursing home residents. The OBRA 87 revisions included the development of federal standards in three major areas: (1) requirements for providers who participate in the Medicare and Medicaid programs;⁴⁹ (2) patient outcome-focused survey and certification processes for evaluating compliance with participation requirements;⁵⁰ and (3) sanctions and enforcement procedures to respond to noncompliance.⁵¹ Implementation of these regulations followed in two stages. Regulations relating to conditions of participation were effective by October 1990.⁵² However, enforcement regulations were delayed until July 1995, purportedly due to their controversial nature and the large volume of comments received during the rulemaking process.⁵³

1. *Participation requirements*

Pursuant to OBRA 87, nursing homes that provide skilled nursing care or rehabilitation services, "must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care."⁵⁴ HCFA

48. OBRA 87, *supra* note 8.

49. See 42 U.S.C. § 1395i-3(b) (1994 & Supp. 1999).

50. See *id.* § 1395i-3(g).

51. See *id.* § 1395i-3(h).

52. QUALITY STANDARDS REPORT, *supra* note 1, at 7.

53. See *id.*

54. 42 U.S.C. § 1395i-3(b)(2) (Supp. 1999). Facilities that provide skilled nursing care are referred to as "skilled nursing facilities" in the federal participation regulations.

implements this mandate through regulations regarding participation requirements for nursing homes.⁵⁵ To achieve the goal of providing quality care that maximizes each resident's potential (and therefore, become certified under Medicare and Medicaid), nursing homes must satisfy over 130 separate requirements⁵⁶ including:

- conducting annual assessments of each individual resident;⁵⁷
- creating individualized care plans;⁵⁸
- reducing the use of chemical and physical restraints;⁵⁹
- ensuring that nursing assistants receive additional training in the care of persons with cognitive impairments;⁶⁰
- providing basic services, including: nursing services, dietary services, physician services, specialized rehabilitation services, dental services, and pharmacy services;⁶¹ and
- enforcing and protecting residents' rights, which include the right to choose a personal attending physician, the right to privacy and confidentiality, the right to participate in residents' groups and visits with family members, and other rights that emphasize the individual dignity of nursing home residents and their entitlement to be free from abuse and neglect.⁶²

The extent of a nursing home's compliance with the foregoing requirements of participation is verified through a survey process. HCFA delegates the survey process to the agency in each state that has responsibility for inspecting and licensing nursing homes within that state.⁶³ The state survey agency must certify that nursing homes participating in federal funding programs meet all requirements of participation.⁶⁴ It should be emphasized that federal preemption in the area of nursing home regulation is not complete. States may set their own

55. *See id.*

56. *See* 42 C.F.R. §§ 483.10-.75 (2001).

57. 42 U.S.C. § 1395i-3(b)(3) (1994 & Supp. 1999).

58. *Id.* § 1395i-3(b)(2).

59. *Id.* § 1395i-3(c)(1)(A)(ii).

60. *Id.* § 1395i-3(b)(5)(E).

61. *See id.* § 1395i-3(b)(4) (Supp. 1999); 42 C.F.R. §§ 483.10-.75 (2001).

62. 42 U.S.C. § 1395i-3(c) (1994 & Supp. 1999).

63. *See id.* § 1395i-3(g)(1)(A).

64. *See id.* HCFA (now CMS) retains responsibility for certifying the compliance of state-owned skilled nursing facilities with federal participation requirements.

standards that nursing homes must meet in order to operate, provided that such standards do not conflict with federal mandates.⁶⁵ In effect, the federal nursing home standards serve as baseline requirements, and states are free to impose standards that are more stringent than those imposed under federal law.⁶⁶

2. *Survey procedures*

In order to operate, nursing homes must be licensed by the state in which they are located.⁶⁷ As noted above, nursing homes also must be certified by the federal government to participate in federal funding programs, including Medicare and Medicaid. Each state has a survey agency responsible for inspecting and licensing nursing homes. The state survey agency serves a dual role in that it also conducts surveys on behalf of HCFA to determine whether nursing homes meet (and continue to meet) participation requirements for certification under Medicare and Medicaid.⁶⁸ HCFA is responsible for ensuring that nursing homes comply with federal mandates,⁶⁹ and it contracts with one agency in each state for the purpose of conducting surveys to evaluate the extent of compliance with federal participation standards.⁷⁰

The state agency conducts two types of surveys. The first, known as a “standard survey,” must be conducted without notice at least once every fifteen months.⁷¹ If an individual provides a nursing home with advance notice of a standard survey, that person is subject to a civil monetary penalty not to exceed \$2,000.⁷² During the standard survey, the survey team evaluates a nursing home’s compliance with both federal participation requirements and the state’s licensure laws.⁷³ The standard survey generally entails “a team of state surveyors spending several days on site conducting a broad review of care and services with regard to

65. *See id.*

66. *See id.*

67. 42 U.S.C. § 1395i-3(d)(2)(A) (1994 & Supp. 1999).

68. *See id.* § 1395i-3(g)(1)(A).

69. *See CALIFORNIA REPORT, supra* note 7, at 6.

70. *See id.*

71. *See* 42 U.S.C. § 1395i-3(g)(2)(A)(iii)(I) (1994 & Supp. 1999); 42 C.F.R. § 488.308 (2001).

72. 42 U.S.C. § 1395i-3(g)(2)(A)(i) (1994 & Supp. 1999).

73. *See CALIFORNIA REPORT, supra* note 7, at 6.

meeting the assessed needs of the residents.”⁷⁴ The surveyors evaluate medical, nursing and rehabilitative care, dietary and nutrition services, activities and social participation, and physical plant characteristics.⁷⁵ The survey team also reviews a sampling of residents’ care plans and assessments to determine accuracy and adequacy.⁷⁶ In addition, the surveyors evaluate the facility’s compliance with and promotion of residents’ rights.⁷⁷ If the surveyors find that a nursing home has failed to meet any applicable federal or state requirement or regulation, they can cite the nursing home for a deficiency that may lead to enforcement action against the facility.⁷⁸ The surveyors have at their disposal an arsenal of federal and state sanctions that can be used to punish noncompliant nursing homes.

The other form of “survey” is a complaint investigation. A complaint investigation typically involves a targeted review focused on a specific complaint that has been lodged against the nursing home.⁸⁰ When a complaint is received, the state agency must complete an investigation of the complaint within a certain period of time depending on the seriousness of the allegation.⁸¹ In general, states apply HCFA’s classification and sanctioning scheme for deficiencies cited during standard surveys. For complaint investigations, however, the state agency generally applies the state’s classification and penalty scheme.⁸² In most cases, HCFA accepts the reporting and recommendations of the state survey agency, but it is free to modify the state agency’s assessment if it chooses to do so.⁸³

The federal survey and certification system created under OBRA 87 changed the focus of the nursing home survey from paper compliance to patient outcomes. Previously, the survey process was akin to a paper review, as surveyors reviewed the records of nursing facilities to

74. *Id.*

75. 42 C.F.R. § 488.305 (a)(2) (2001).

76. *Id.* § 488.304 (a)(3).

77. *Id.* § 488.305 (a)(4).

78. *See id.* § 488.330.

80. *See CALIFORNIA REPORT, supra* note 7, at 5.

81. *See id.*

82. *See id.* at 6. *See* 42 U.S.C. § 1395i-3(g)(4) (Supp. 1999).

83. *See QUALITY STANDARDS REPORT, supra* note 1, at 5; 42 C.F.R. § 488.452 (2001).

determine compliance with participation requirements.⁸⁴ The OBRA 87 survey is a more hands-on process that examines facility operations and staff interactions with residents to determine whether the facility is providing quality care to residents. Under OBRA 87, deficient providers face a range of sanctions that may be imposed based on the level of seriousness of the identified deficiency.

3. Sanctions

OBRA 87 is in accord with the IOM's recommendation for stronger regulatory enforcement. In an effort to ensure that nursing homes achieve and maintain an acceptable level of compliance with the conditions of participation, OBRA 87 greatly expanded the range of enforcement sanctions that may be imposed on poorly performing nursing homes. The IOM Report noted that many nursing homes tend to cycle in and out of compliance.⁸⁵ Prior to OBRA 87, the only sanctions available for noncompliance were termination from the Medicare or Medicaid program⁸⁶ or, under certain circumstances, denial of payments for new Medicare or Medicaid residents.⁸⁷ In addition to denial of payments and termination of program participation, OBRA 87 expanded the sanctions arsenal to include the following:

- (1) civil monetary penalties, ranging from \$50 to \$10,000 per day;⁸⁸
- (2) appointment of a substitute manager by the state survey agency, with authority to hire, fire, and reassign staff, obligate funds, and alter facility procedures as appropriate;⁸⁹
- (3) directed in-service training, whereby a facility is required to train staff on a specific issue identified as a problem during a

84. See generally Terri D. Keville et al., *Seventeenth Annual Health Law Symposium: Recent Developments in Long-term Care Law and Litigation*, 20 WHITTIER L. REV. 325 (1998) (discussing the survey process pre- and post-OBRA 87).

85. IOM REPORT, *supra* note 21, at 148-49.

86. Approximately eighty-six percent of all nursing homes are Medicare-certified or Medicare- and Medicaid-certified. Fourteen percent of all nursing homes have Medicaid certifications only. QUALITY STANDARDS REPORT, *supra* note 1, at 5.

87. See *id.* at 5.

88. 42 C.F.R. § 488.406 (a)(3) (2001).

89. *Id.* § 488.406 (a)(1).

survey;⁹⁰

(4) directed plan of correction, whereby a facility is required to take action within a specified time frame according to a plan of correction developed by HCFA, the state enforcement agency, or the temporary manager;⁹¹

(5) placement of a state monitor in the nursing facility to help ensure that the facility achieves and maintains compliance;⁹² and

(6) transfer of residents and closure of the facility.⁹³

Congress intended the new OBRA 87 sanctions, particularly civil monetary penalties, to provide a strong incentive for nursing homes to achieve and maintain compliance with the conditions of participation in Medicare and Medicaid. The sanctions were implemented through regulations that reflected HCFA's approach to the conditions of participation—that all standards must be met and enforced, but the significance of a particular violation depends on the circumstances and the actual or potential effect on residents.

The regulations create a framework for evaluating the relative seriousness of each instance of noncompliance with participation requirements, and tie the appropriate sanctions to the seriousness of the identified deficiencies.⁹⁴ The level of seriousness is determined by consideration of whether a facility's deficiencies constitute: (a) no actual harm with a potential for minimal harm;⁹⁵ (b) no actual harm with a potential for more than minimal harm, but not immediate jeopardy;⁹⁶ (c) actual harm that is not immediate jeopardy;⁹⁷ or (d) immediate jeopardy to resident health or safety.⁹⁸ The agency also must determine if the deficiencies: (a) are isolated;⁹⁹ (b) constitute a pattern;¹⁰⁰ or (c) are

90. *Id.* § 488.406 (a)(8).

91. *Id.* § 488.406 (a)(7).

92. *Id.* § 488.406 (a)(4).

93. *Id.* § 488.406 (a)(6).

94. *See* § 488.408. In this section, the remedies identified in § 488.406 are classified into three categories. The level of seriousness of the deficiency determines the category of remedy that is applicable to the deficiency.

95. *Id.* § 488.404 (b)(1)(i).

96. *Id.* § 488.404 (b)(1)(ii).

97. *Id.* § 488.404 (b)(1)(iii).

98. *Id.* § 488.404 (b)(iv).

99. *Id.* § 488.404 (b)(2)(i).

100. *Id.* § 488.404 (b)(2)(ii).

widespread.¹⁰¹ Obviously, deficiencies that involve immediate jeopardy to the health or safety of residents are the most serious and are responded to with the most aggressive remedies.

Nursing homes that are in “substantial compliance,” which means that they have no serious deficiencies, are not subject to sanctions.¹⁰² Serious deficiencies, on the other hand, may be remedied with the imposition of multiple sanctions. Moreover, a history of noncompliance places a facility at risk for the imposition of the most stringent remedies. For example, if a facility is cited for deficiencies during its last three consecutive standard surveys, denial of payments for all new admissions and state monitoring will be imposed automatically.¹⁰³

II. THE NEW ENVIRONMENT

A. *Life After OBRA 87*

OBRA 87 completely changed the method for monitoring nursing homes for compliance with the conditions of participation in the Medicare and Medicaid programs. Nursing homes and regulators alike have spent the past ten years becoming familiar with and applying the OBRA 87 survey requirements and enforcement remedies. Recently, the survey and enforcement mechanisms created under OBRA 87 have been criticized as being ineffective and too lenient on the nursing home industry. Such criticisms seem unfair, as the changes ushered in by OBRA 87 have barely had sufficient time to take hold. Indeed, the enforcement regulations have only been in place since 1995. Regardless, legislators and citizen groups calling for crackdowns on the nursing home industry have found a receptive audience. In fact, a witch-hunt mentality has taken hold, and both federal and state regulators are being pressured into adopting a take-no-prisoners approach to nursing home enforcement.¹⁰⁴ Rather than working with the nursing home industry to perfect systems and procedures designed to ensure that nursing home residents receive the best care possible, regulators have shifted the emphasis (and resources) to ferreting out, punishing, and even criminalizing instances of noncompliance with participation standards. The fundamental question

101. *Id.* § 488.404 (b)(2)(iii).

102. *See* QUALITY STANDARDS REPORT, *supra* note 1, at 8-9.

103. 42 C.F.R. § 488.414 (2001).

104. *See* Childs, *supra* note 10, at 36-37.

that must be addressed is whether this new punitive approach will only serve to exacerbate the problems that it seeks to remedy. Nursing homes may be forced to make the Hobson's choice of either shifting already strained resident care resources to regulatory compliance efforts or running the risk of incurring harsh penalties that could drive many facilities out of business.

B. Senator Grassley's Indictment of California Nursing Homes

In July 1998, the General Accounting Office (GAO) released a damning study of the California nursing home industry.¹⁰⁵ At the request of the United States Senate Special Committee on Aging, chaired by Senator Charles Grassley (R) of Iowa, the GAO reviewed data from nursing home surveys conducted by the California Department of Health Services (DHS), the state survey agency, between 1995 and 1998.¹⁰⁶ The GAO found that 407 nursing homes, or nearly one-third of the state's nursing homes, were cited for deficiencies involving death or serious harm to residents.¹⁰⁷ Moreover, the GAO sampled the sixty-two cases of California nursing home residents who died in 1993 and found that thirty-four of the residents received unacceptable care, including unexplained and unmonitored weight loss, as well as improperly treated pressure sores.¹⁰⁸

Although DHS issued a significant number of citations during the period covered by the study, the GAO believed that the state surveyors were able to uncover only a portion of care-related problems existing in California's nursing homes.¹⁰⁹ According to the GAO, despite the presence of a complex federal and state oversight infrastructure, a significant number of California nursing homes were not sufficiently monitored to ensure the safety and well-being of nursing home residents.

The GAO blamed the predictability of annual surveys, inaccurate or

105. See *California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes with Serious Care Violations, Testimony Before the Senate Special Comm. on Aging*, 105th Cong. 6 (1998), [hereinafter *Scanlon California Statement*] available at <http://www.gao.gov/archive/1998/he98219t.pdf> (statement of William J. Scanlon, Director, Health Financing and Systems Issues, Health, Education, and Human Services Div., GAO).

106. *Id.*

107. *Scanlon California Statement*, *supra* note 105, at 6.

108. *Id.* at 5.

109. See *id.* at 7.

otherwise misleading entries in medical records, and limitations in survey methods prescribed by HCFA for the alleged understatement of deficiencies.¹¹⁰ In particular, the GAO took issue with HCFA's procedure for selecting a sample of residents for review. HCFA's procedure does not call for randomly selecting a sufficient sample of residents; instead, HCFA relies upon the professional expertise and judgment of the surveyors to identify the resident cases to be reviewed.¹¹¹ In the GAO's view, the lack of random sampling by HCFA permits cases of substandard care to escape scrutiny.

The GAO report was most critical of the enforcement mechanisms in California. The GAO noted that between July 1995 and March 1998, DHS surveyors cited 122 homes in both of their last two surveys for conditions involving actual harm or immediate jeopardy to residents, yet HCFA enforcement policies led to very few federal disciplinary actions against these homes.¹¹² In fact, despite the variety of new enforcement sanctions available under OBRA 87, only 33 of the 122 homes were penalized with federal sanctions.¹¹³ The GAO cited "HCFA's forgiving stance toward homes with a 'ping-pong' history of compliance" as the reason that nursing homes with citations involving immediate jeopardy or actual harm escape federal sanctions.¹¹⁴

According to the GAO, only two percent of survey deficiencies cited during the study period were referred to HCFA for the immediate imposition of remedies.¹¹⁵ The other ninety-eight percent of noncompliant nursing homes were granted a grace period to correct the cited deficiencies, regardless of the facilities' past performance.¹¹⁶ To be fair, however, the GAO noted that nationwide, the percentage of noncompliant nursing homes that receive a grace period to correct deficiencies is higher—ninety-nine percent.¹¹⁷

The GAO found it troubling that, pursuant to HCFA policy, DHS and other state survey agencies do not appear to take into account a nursing

110. *See id.*

111. *Id.* at 9.

112. *Id.* at 10.

113. *Id.*

114. *Id.*

115. *Id.* at 11.

116. *Id.*

117. *Id.*

home's compliance history in determining whether a grace period should be granted.¹¹⁸ As a result, the GAO concluded that noncompliant facilities have managed to avoid sanctions year after year, and thus, they have little incentive to ensure that cited deficiencies are effectively corrected.¹¹⁹

Curiously, DHS did not appear to be the target of the GAO report. Rather, the message of the report seemed to be "you're only as good as the tools you have to work with, and HCFA hasn't provided you with the right tools."¹²⁰ Caught in the middle, however, DHS reacted to the GAO report with an impassioned defense of its own efforts to regulate the state's nursing home industry, while openly chastising HCFA and Congress for failing to provide the leadership and resources necessary to ensure that nursing homes are fully committed to providing quality care to residents.¹²¹

In her written testimony to the Special Committee on Aging, S. Kimberly Belshé, Director of DHS, defended DHS's oversight of the nursing home industry in California.¹²² She assured the public and family members of DHS's dedication to ensuring that nursing home residents live in a nurturing, safe environment.¹²³ Further, she noted that contrary to the impression created by the GAO report, California has been at the forefront of the implementation of the OBRA 87 survey and enforcement process.¹²⁴ Ms. Belshé based her views on the quality of surveys, training of staff, number of deficiencies cited and remedies imposed, including \$2.1 million in federal civil monetary penalties assessed between February 1996 and April 1998.¹²⁵

Ms. Belshé also took issue with the methodology of the GAO study. Specifically, she criticized its focus on deaths that occurred in nursing homes two full years prior to the implementation of OBRA 87

118. *See id.* at 12.

119. *See id.*

120. *Id.*

121. *See* S. Kimberly Belshé, Director, California Dep't of Health Services, *Written Testimony Prepared for the U.S. Senate Special Comm. on Aging*, at 2 (July 28, 1998), <http://www.dhs.ca.gov/lnc/nhomegao/testimony.htm> (on file with author).

122. *See id.*

123. *See id.*

124. *See id.* at 2.

125. *See id.*

enforcement regulations in 1995.¹²⁶ Particularly compelling was Ms. Belshé's observation that if the intention of the report was to evaluate the effectiveness of the OBRA 87 survey and enforcement process, the study should have focused on events that occurred following full implementation of the OBRA 87 regulations.¹²⁷

Ms. Belshé closed her written testimony with detailed recommendations to Congress and HCFA for improving the federal survey and enforcement process. She specifically entreated Congress to increase funding to HCFA so that the predictability of surveys could be decreased and the number of surveys could be increased.¹²⁸ She also called for the enactment of federal penalties for medical records falsification, referring to the GAO's observation that the questionable thoroughness and accuracy of medical records likely shielded many problems from surveyor scrutiny.¹²⁹ Ms. Belshé further recommended that HCFA: (1) make the survey process more stringent by requiring a "revisit" survey to verify correction of all cited deficiencies; (2) increase the states' survey budgets to reflect the cost of performing a "quality" survey, as opposed to an "average" survey; (3) study the differences in survey and enforcement implementation between regions of the country and formulate "best practices" recommendations that can be shared and utilized by all state survey agencies; (4) fund abbreviated surveys for all complaints; and (5) revise the federal certification and survey database so that it provides vital enforcement data in a usable format.¹³⁰

The GAO's study of the California nursing home industry called attention to serious problems with the quality of care being provided in many nursing homes.¹³¹ Obviously, such problems are not limited to California. However, the California study revealed significant problems with the manner in which HCFA and the state survey agencies have implemented the OBRA 87 survey and enforcement process.¹³²

126. *See id.* at 3.

127. *See id.* ("This disconnection between the GAO's focus—the effectiveness of nursing home oversight in the context of OBRA 1987—and the data used in part, calls into question the appropriateness of applying the report's findings to the current OBRA process, especially in 1998.")

128. *See id.* at 4.

129. *See id.*

130. *Id.* at 4-5.

131. *See id.* at 3.

132. *Id.*

Following the issuance of the GAO report, the federal government launched an initiative aimed at improving the quality of care provided to the nation's nursing home residents.¹³³ Individual state legislatures have also introduced a variety of new proposals to regulate the nursing home industry.¹³⁴ The primary purpose behind many of these initiatives has been to create new layers of regulation and to increase both the severity and imposition of penalties imposed on noncompliant nursing homes.¹³⁵ Unfortunately, the GAO's criticisms directed to correct the inadequacies of the enforcement community itself have largely been lost in the shuffle. It is incongruous that the regulatory community would pursue new mandates when evidence shows that historically, regulators have been ineffective and inconsistent in the implementation and application of existing regulatory requirements.

C. President Clinton's 1998 Nursing Home Quality Initiative

HCFA launched the Nursing Home Quality Initiative in July 1998 as an ameliorative response to the GAO report on the California nursing home industry. President Clinton unveiled the initiative during a televised news conference, during which he committed to strengthening state enforcement and federal oversight of the nursing home industry.¹³⁶ The President announced several new administrative actions to be implemented by HCFA, including:

- imposing penalties immediately upon finding that a nursing home has committed a serious or chronic violation, thereby doing away with grace periods for facilities with repeated violations;¹³⁷
- strengthening the states' inspection of nursing homes by staggering survey times, performing surveys during evenings and weekends, and targeting poorly performing facilities with more frequent inspections;¹³⁸ and

133. See QUALITY STANDARDS REPORT, *supra* note 1, at 2.

134. See *id.* at 26.

135. See *id.* at 3-4.

136. See Press Release, U.S. Dep't of Health & Human Servs., Clinton Administration Announces New Initiative to Improve the Quality of Care In Nursing Homes (July 21, 1998), available at <http://www.hhs.gov/news/press/1998pres/980721a.html>.

137. *Id.*

138. *Id.*

- referring egregious violations of quality of care standards to the Office of Inspector General and the Department of Justice for investigation, and, if appropriate, prosecution.¹³⁹

President Clinton also stated that HCFA would increase its oversight of the state survey agencies and take decisive action against states that are failing to enforce standards.¹⁴⁰ These actions include terminating federal nursing home inspection funding to states where oversight of the nursing home industry clearly is inadequate.¹⁴¹ HCFA took the President's directives seriously and expanded states' abilities to impose fines as high as \$10,000 per survey infraction, eliminated grace periods for facilities with repeated violations,¹⁴² and directed states to begin criminal investigations of complaints involving resident harm within ten days of receipt.¹⁴³

Nursing home industry representatives have encountered a complete change in the manner in which the regulatory community views the industry. Linda Keegan, vice president of the American Health Care Association, a national nursing home industry organization, characterized the new environment very plainly: "It's become truly an us versus them environment. The administration's emphasis is on punishment, not fixing the system's problems."¹⁴⁴ This sentiment has been echoed by other industry representatives, including Stephen Guillard, CEO of Boston's Harborside Healthcare, who likewise observed:

We have seen instance after instance where a company and its officials, with a superb track record, are not given any leeway to enter into an agreement to correct problems that occur. Zero tolerance for deficiencies that are not life-threatening has become the norm, and as a result more beds are now facing decertification than at any other point in the history of the industry.¹⁴⁵

139. *Id.*

140. Childs, *supra* note 39.

141. *See id.* Ominously, President Clinton stated: "If state enforcement agencies don't do enough to monitor nursing home quality, we will cut off their contracts and find someone else who will do it right." Nathan Childs, *How Will Long Term Care Remember the Clinton Years?* PROVIDER, Nov. 1999, at 39.

142. *See* QUALITY STANDARDS REPORT, *supra* note 1, at 8-9.

143. *See* CALIFORNIA REPORT, *supra* note 7, at 5.

144. Childs, *supra* note 113, at 39.

145. *Id.*

The “zero tolerance” approach has been reflected in more recent federal nursing home initiatives. For example, in December 1998, HCFA and the United States Department of Justice announced that they would work together to develop guidelines for prosecuting nursing home cases involving “egregious” violations.¹⁴⁶ During a subsequent working group conference, Deputy Attorney General Eric H. Holder, Jr. informed law enforcement representatives and nursing home regulators that “[i]f [nursing] facilities know that you are meeting regularly with regulators and law enforcement to discuss inadequate care in nursing homes, that coordination alone can be a very powerful incentive for problem facilities to improve the care they provide.”¹⁴⁷

In addition, on December 14, 1999, HCFA announced that nursing homes found to have isolated incidents of physical harm to residents would be subject to immediate fines of up to \$10,000 per instance of abuse.¹⁴⁸ This new policy expanded previous enforcement rules that called for immediate fines after patient harm was determined to be widespread or habitual within a facility. Based upon state survey data from 1998, HCFA projected that approximately twelve percent of the nation’s seventeen thousand nursing homes would face immediate sanctions under the new policy, which imposes fines on nursing homes found to have harmed a resident during two consecutive state surveys.¹⁴⁹

Moreover, the Clinton administration asked Congress to add \$15.9 million in fiscal year 2001 to improve oversight of the nation’s nursing homes.¹⁵⁰ This increased funding will be used to provide more training to nursing home surveyors, increase the number and frequency of unannounced surveys, and more closely supervise the nation’s hundred worst-performing nursing facilities.¹⁵¹

However, the request for increased funding was not uniformly well-

146. See HCFA, *DOJ Develop Plan for Prosecuting Nursing Home Violations, Report Says*, DAILY REP. FOR EXEC. (BNA) No. 248, Dec. 29, 1998, at A18.

147. *Enforcement Officials Urge Interdisciplinary Approach to Prevent Nursing Home Abuses*, DAILY REP. FOR EXEC. (BNA) No. 207, Oct. 27, 1999, at A25.

148. See HCFA *Announces New Sanctions to Curb Isolated Incidents of Nursing Home Abuse*, DAILY REP. FOR EXEC. (BNA) No. 240, Dec. 15, 1999, at A31.

149. *Id.*

150. See Clinton Hopes to Improve Nursing Homes By Adding \$15 Million to Inspect Conditions, DAILY REP. FOR EXEC. (BNA) No. 11, Jan. 18, 2000, at A21.

151. See *id.*

received. Senator Grassley, a vocal HCFA critic, warned that throwing money at nursing home oversight is not the solution to the industry's ills.¹⁵² Senator Grassley remarked that HCFA does a "poor job" of overseeing its regional offices, which, in turn oversee the state survey agencies, and added that until HCFA improves its oversight, "[w]e could quadruple enforcement money with no guarantees of success. It's like throwing cash into a river."¹⁵³ The nursing home industry was equally pointed in its criticism of the requested funding increase, arguing that the money would be better spent on increasing federal payments to nursing homes, thus enabling them to hire additional patient caregivers. The nursing home industry regards this step as "the key to quality health care in any setting."¹⁵⁴

As the foregoing discussion demonstrates, the federal government has actively pursued the nursing home industry through a variety of initiatives, all of which ostensibly are aimed at improving the quality of care delivered in the nation's nursing homes. The effectiveness of the initiatives continues to be a subject of debate. On one side are the hard-line regulators who want greater ability to punish nursing homes that fail to comply with participation requirements. On the other side are the nursing home administrators who seek a cooperative and problem-solving approach to nursing home regulation. Presently, it appears that the hard-liners are gaining the upper hand, and now, states are joining the debate. For example, since 1997 the State of Delaware has completely revamped how it monitors nursing homes for compliance with federal and state regulatory requirements, and how it penalizes homes when they fall short of those requirements. Regrettably, as has been the case with the federal reform initiatives, the emphasis has been on formulating new regulations rather than requiring the regulators to improve their survey and enforcement processes. Pursuing new regulations is an irrational response,

152. *See id.* at A22.

153. *Id.*

154. *Id.* (quoting Linda Keegan, Vice President, American Health Care Association). Interestingly, on November 3, 1999, the U.S. Senate Special Committee on Aging held a forum on nursing home staffing problems. Panelists cited several causes for staffing shortages, including inadequate federal funding for long term care, the lack of national minimum staffing requirements and the stress and low pay of nursing home employment. *See Nursing Home Understaffing Blamed on Low Pay, High Stress, Poor Funding*, DAILY REP. FOR EXEC. (BNA) No. 213, Nov. 4, 1999, at A32.

since the problem is how compliance with the already voluminous regulations is evaluated and enforced.

D. Delaware Nursing Home Reform

1. State legislative and citizens investigative panel

On September 29, 1997, Delaware State Senator Robert Marshall held a press conference to announce the formation of the State Legislative and Citizens Investigative Panel on Nursing Home Reform ("Panel").¹⁵⁵ The Panel was created for the purpose of conducting the first comprehensive investigation of Delaware nursing home practices since the 1960s. Senator Marshall chaired the fourteen-member Panel, which was comprised of state legislators, representatives of the American Association of Retired Persons, attorneys with expertise in elder law issues, and members of the general public with various associations with the long-term care industry.¹⁵⁶

On October 27, 1997, and October 30, 1997, public hearings regarding nursing home reform were held in New Castle County, Delaware.¹⁵⁷ Earlier that month, similar hearings took place in Delaware's two other counties, Kent and Sussex. The October hearings were held for the purpose of eliciting testimony from members of the general public regarding their experiences with nursing homes located in Delaware. Senator Marshall opened the first New Castle County hearing by stating that the Delaware nursing home industry was in need of major change and improvement. He noted that the Panel intended to formulate legislation to address perceived deficiencies in the industry.¹⁵⁸ After

155. For reference to the Panel's formation, see STATE LEGISLATIVE AND CITIZENS INVESTIGATIVE PANEL ON NURSING HOME REFORM, REPORT TO THE PEOPLE OF THE STATE OF DELAWARE 3 (1998) [hereinafter Panel Report] (on file with author).

156. *See id.* at 1.

157. The author followed the activities of the Panel and attended several of the public hearings on nursing home reform discussed herein. The testimony presented to the Panel and the events of the public hearings are recounted from the notes of the author, unless otherwise indicated.

158. The mission statement of the Panel was described as follows:

The purpose of the Legislative and Citizens Investigative Panel on Nursing Home Reform is to ensure that residents of Delaware nursing homes are safe and secure, are receiving quality care, and are free from

Senator Marshall concluded his initial remarks, several members of the audience were called to relate stories of abuse and neglect of nursing home patients.¹⁵⁹ The incidents ranged from insensitive and disparaging remarks directed to residents and family members by facility staff to extreme physical and mental abuse of residents by staff.¹⁶⁰

Neglect and inadequate supervision were also common complaints. One woman stated that her wheelchair-bound mother, who suffered from dementia, passed undetected through an emergency exit door and fell down a flight of stairs, with the wheelchair landing on top of her. Over six hours passed before facility staff discovered that the woman was missing, and several more hours passed before she was located in the stairwell. Despite the ordeal, the resident survived.

Occasionally, there was a bright spot in the public testimony, as a few family members informed the Panel that their loved ones had received compassionate and expert care while residing in particular nursing facilities. However, the Panel made it clear that it did not welcome such comments, and a Panel member even accused one family member of being “put up” to his testimony by nursing home administrators.¹⁶¹ Given the Panel’s mission to recommend reforms for the nursing home industry, it is not surprising that the Panel denounced any testimony that suggested many nursing homes were already providing high quality care. Rather, the Panel actively solicited horror stories, and many Delaware facilities were implicated in the fray.

One point that Panel members, nursing home administrators, and family members uniformly agreed upon was the difficulty of attracting and retaining competent and compassionate caregivers, particularly Certified Nursing Assistants (CNAs). According to figures provided by the U.S. Senate Special Committee on Aging, CNAs provide at least

abuse, neglect and financial exploitation.

Panel Report, *supra* note 155, at 2.

159. *See id.* at 4.

160. Author’s notes; Panel Report, *supra* note 155, at 4.

161. Senator Marshall took up the cause of nursing home reform after his father passed away in a Delaware nursing facility. Senator Marshall’s motivation is reflected in the preamble to minimum staffing legislation introduced by the Senator, which reads: “This Act shall be referred to and cited as ‘Eagle’s Law’ in memory of Ignatius Adam ‘Eagle’ Marshall, patriot, husband and father, whose experiences in a Delaware nursing facility inspired this legislation.” S. 115, 140th Gen. Assem. (Del. 1999).

eighty percent of the patient care in nursing facilities nationwide, and the average wage for CNAs is \$6.94 per hour.¹⁶² The turnover rate among CNAs is between eighty to ninety percent annually.¹⁶³ Several witnesses and Panel members noted that although CNAs are primarily responsible for ensuring that residents' physical needs are attended to, they frequently are ill-equipped to provide the necessary care in a manner that recognizes and promotes the dignity of the residents. Specific problems identified by the witnesses and Panel members included: a lack of training; a lack of accountable supervision; a lack of suitable temperament for the job, which can be both physically and mentally demanding; overwhelming caseloads that prevent CNAs from giving adequate attention to any one resident; and inadequate compensation (\$6.00 to \$10.00 per hour was common in Delaware at that time), which may discourage better qualified and more reliable candidates from applying for CNA positions.¹⁶⁴

It was clear that the vast majority of the speakers at the public hearings intended to underscore the need for reform, rather than to extol the virtues of the nursing home industry. Unquestionably, their messages touched a nerve in Delaware. The hearings and testimony received widespread media coverage, sparking numerous letters to local newspapers both for and against the nursing home industry. For the most part, however, the news accounts and letters focused on the horror stories, rather than the positive experiences.

In November and December 1997, other prominent players in the Delaware nursing home industry had the opportunity to publicly address the comments made during the October public hearings. First, the state agencies with oversight responsibilities presented testimony to the Panel. The Division of Public Health, the Office of Health Facilities Licensing and Certification ("Health Facilities"), which at that time was responsible for licensing and surveying long-term care facilities in the state, the Office of the Long-term Care Ombudsman, which serves as an advocate for

162. See *Nursing Home Understaffing Blamed on Low Pay, High Stress, Poor Funding*, DAILY REP. FOR EXEC. (BNA) No. 213, Nov. 4, 1999, at A33.

163. See *id.*

164. Delaware nursing homes are facing a particularly difficult staffing shortage, as the unemployment rate statewide is low (totalling 3.2 percent in September 2001, with a rate of 3.1 percent in New Castle County, the state's population center). See Delaware Department of Labor's Office of Occupational and Labor Market Information, *available at* <http://www.oolmi.net/data/lausfin.htm> (last visited Dec. 18, 2001).

residents, the state Medicaid Office, the Division of Aging, and the Delaware Attorney General's Office all were represented at the agency hearing.¹⁶⁵ In general, the state agencies agreed with the Panel that Delaware nursing homes urgently need more effective oversight. However, rather than pointing to a lack of regulation as the culprit, the agencies advocated for more funding and increased staffing, saying that the lack of resources impedes the enforcement community's abilities to deter, detect and punish providers of substandard care.

Representatives of nursing facilities had an opportunity to respond to the many concerns voiced during the various hearings on December 10, 1997. The industry hearing attracted a large audience, in part because the public was interested in the industry's response to the numerous criticisms that were lodged against nursing homes during the preceding two months of public hearings. While industry representatives recognized that there was room for improvement, they uniformly agreed that additional regulation would not remedy the identified problems. Indeed, one speaker noted that the nursing home industry already is one of the most heavily regulated industries in the United States, second only to nuclear power. Instead, the industry proposed that the Panel consider ways to improve the training, supervision, accountability, compensation and job satisfaction of primary caregivers. The Panel received the industry's recommendations with polite interest, but nonetheless clearly expressed that it intended to pursue new laws and regulations to address the concerns raised during the hearings.¹⁶⁶

165. The Division of Public Health, Office of Health Facilities Licensing and Certification was the state agency designated by HCFA to survey skilled nursing facilities in order to ensure compliance with the federal conditions of participation. *See generally* 42 C.F.R. § 483 (2001). One of the legislative enactments that resulted from the Panel's work was the reconstitution of Health Facilities into the newly-created Division of Long-term Care Resident Protection.

166. Another circumstance strengthened the Panel's resolve to legislate reform. In the fall of 1997, Doctor Gregg C. Sylvester, then Director of the Division of Public Health, in effect overruled a survey report issued by Health Facilities. (At that time, Health Facilities was an agency of the Division of Public Health.) The Director retracted over twenty-eight pages of survey violations relating to the Harbor Healthcare and Rehabilitation Center in Sussex County, Delaware. Senator Marshall, the Chairman of the Panel, was openly critical of the Director's actions and noted that he was troubled by the perception that a state agency charged with nursing home oversight had treated a facility as a customer. In his view, the facility's residents are the state's customers.

2. *The Panel's recommendations*

On February 9, 1998, the Panel issued its "Report to the People of the State of Delaware."¹⁶⁷ In the report, the Panel developed findings and recommendations for eight areas of policy review that it evaluated.¹⁶⁸ The following discussion represents a summary of the areas of policy review, and the Panel's findings and recommendations.

a. Creation of the Division of Long-term Care

The Panel discovered that the state agencies, responsible for overseeing Delaware's nursing homes, had failed to coordinate and communicate effectively, thereby fragmenting nursing home regulation.¹⁶⁹ The Panel noted that in some instances, the agencies work at cross-purposes.¹⁷⁰ Therefore, the Panel recommended the creation of a Division of Long-term Care under the Delaware Department of Health and Social Services.¹⁷¹ All of the state agencies responsible for nursing home regulation would be reclassified under the new division and would share a common location. In addition, computer support would be integrated to facilitate the creation of a centralized database for efficient coordination.

b. The Office of the Long-term Care Ombudsman

Throughout the public hearings, serious accusations of malfeasance were directed at the Office of the Long-term Care Ombudsman ("Ombudsman's Office"), particularly with respect to its handling of abuse and neglect complaints. Therefore, it was not surprising that the Panel Report was critical of the Ombudsman's Office and recommended its complete restructuring.¹⁷² Indeed, the Panel Report noted:

The Panel finds that the Office of Long-Term Care Ombudsman and the Division of Aging have failed in their responsibilities to make sure that the Office complies with its federal and state statutory responsibilities. Despite the efforts of some dedicated employees, the Office is, by its own admission, substantially out of compliance with the federal Older Americans Act. The Panel

167. Panel Report, *supra* note 155.

168. *See id.*

169. *See id.* at 6.

170. *See id.*

171. *See id.*

172. *See id.* at 7-9.

finds that this lack of compliance extends to the Office's state mandates as well.¹⁷³

The Panel also condemned the Ombudsman's Office for lack of administrative leadership and inadequate investigation and follow-up concerning complaints of abuse and neglect.¹⁷⁴

The Panel recommended the reorganization of the Ombudsman's Office beginning with the hiring of a state-wide manager, responsible for "restoring order and structure to the Office and implementing systems and reforms that will bring the Office back into compliance with state and federal law."¹⁷⁵ The Panel also recommended the development of an automated case management tracking system to assist the Ombudsman's Office in documenting abuse and neglect allegations and providing written responses to complainants.¹⁷⁶ In addition, the Panel suggested the allocation of funds for seven new staff positions to handle the expanding caseload of the Ombudsman's Office.¹⁷⁷

c. Appeals process and advisory boards

Based in significant part upon perceived defects in the process whereby nursing homes may appeal deficiencies identified during facility surveys, the Panel recommended that the state Department of Health and Social Services develop a mechanism for handling appeals.¹⁷⁸ The new "appeals authority" would be empowered to hear issues raised by facility residents, regulators, the Ombudsman's Office, and advocates for such persons.¹⁷⁹ In effect, the Panel advocated for the creation of a specialized "court" to hear disputes relating to long-term care.¹⁸⁰ The Panel did not address whether the decisions of the appeals authority would be binding on the parties.¹⁸¹

173. *Id.* at 7.

174. *Id.*

175. *Id.* at 8.

176. *See id.*

177. *See id.*

178. *See id.* at 9.

179. *See id.* at 10.

180. *See id.* at 9.

181. *See id.* at 9-10.

d. Nursing home employee training and development

As anticipated, the Panel recommended significant changes relating to the training and staffing of CNAs.¹⁸² The Panel observed that the then-current requirement of seventy-five hours of training “is insufficient to ensure that CNAs are adequately prepared for the responsibilities of the job,” and recommended an increase to a minimum standard of 120 hours, to include additional training in nutrition.¹⁸³ Moreover, the Panel decried “the shamefully-low wages that many nursing homes pay for CNAs,” and encouraged nursing homes to “accept their responsibility to pay CNAs a living wage commensurate with their responsibilities.”¹⁸⁴

One of the Panel’s more interesting suggestions pertained to CNA job perception and satisfaction. The Panel recommended the establishment of a ‘career ladder’ for CNAs, consisting of at least three levels: intern, team member (greater length of employment would result in increased pay), and team leader/preceptor (additional education would result in increased pay).¹⁸⁵ In the Panel’s view, creating a career ladder would transform the CNA position into a true profession, rather than just a job that is abandoned as soon as something better comes along.

e. Code of ethics and public disclosure

The Panel expressed concern that state employees charged with nursing home oversight were not instructed adequately about conflict of interest issues with regard to their oversight responsibilities. Thus, the Panel recommended workshops for state employees to remind them of their obligations under the state ethics guidelines.¹⁸⁶ In addition, the Panel called for the enactment of legislation that would require nursing homes to disclose to residents and family members the facilities’ relationships with providers of nursing home services, such as pharmacies, rehabilitation services providers and medical suppliers.¹⁸⁷

f. Role of the Office of the Attorney General

During the public hearing process, the Panel repeatedly expressed its

182. *See id.* at 11-12.

183. *Id.* at 16.

184. *Id.* at 11-12.

185. *Id.* at 11.

186. *See id.* at 12.

187. *See id.*

opinion that nursing homes are getting away with widespread abuse because the state enforcement agencies find abuse and neglect cases too difficult to prosecute. These cases often are complicated by the fact that the alleged victim is unable to participate in the state's case in a meaningful way. Thus, it came as no surprise that the Panel recommended amending the physical abuse statutes under Delaware's Health and Welfare Code to eliminate intentional conduct as the relevant prosecutorial standard.¹⁸⁸ The Panel indicated that the statutes should be amended to incorporate a knowing or reckless standard for prosecution.¹⁸⁹ The Panel also requested additional state funding to add two elder abuse investigators, a prosecutor and a secretary, in the Medicaid Fraud Unit to enable the Delaware Attorney General's Office to intervene in abuse and neglect cases in a more timely manner.¹⁹⁰

Another significant Panel recommendation was a proposal to raise a nursing home administrator's failure to report suspected abuse or other violations from a misdemeanor offense to a felony.¹⁹¹ In addition, the Panel advocated for legislation that would require mandatory criminal background checks for any person offered employment by a nursing home, as well as pre-employment drug screening.¹⁹²

g. Nursing home economic issues and interests

During the public hearing process, the Panel addressed the issue of payment for nursing home services.¹⁹³ On the consumer side, witnesses complained that many nursing homes limit the number of Medicaid-certified beds, which reduces placement options for many patients.¹⁹⁴ Consumers also complained about the nursing home practice of requiring third-party payment guarantees.¹⁹⁵ On the nursing home side, the industry representatives expressed concern that new regulations would result in increased costs, yet there was no provision for increasing Medicaid reimbursement rates (which are substantially lower than facilities' private

188. See DEL. CODE ANN. tit. 16, §§ 1131, 1136 (1995).

189. IOM REPORT, *supra* note 15, at 19, §§ 4.2 (b), 4.2 (a).

190. Panel Report, *supra* note 155, at 19.

191. See *id.* at 20.

192. See *id.*

193. See *id.* at 5.

194. See *id.* at 7.

195. See *id.*

payment rates) to support the nursing homes' efforts to comply with the regulations.¹⁹⁶

To address the concerns expressed by both groups, the Panel made several recommendations. First, the Panel called for quarterly adjustment of Medicaid reimbursement rates "to enable nursing homes to be fairly remunerated for services provided to Medicaid patients."¹⁹⁷ The Panel also recommended the creation of a standard admission contract to be used by all Delaware nursing homes, as well as a prohibition on the practice of requiring third parties to personally guarantee payment of nursing home bills.¹⁹⁸ Perhaps the most significant suggestion, from the provider's point of view was the Panel's opinion that if a facility has any Medicaid-certified beds, all the beds in that facility that are available to the general nursing home population must be Medicaid-certified.¹⁹⁹

h. Quality of care

The Panel identified several problems with the quality of care provided in many Delaware nursing homes. These problems included: inadequate daily direct patient care; claims by certain nursing homes of possessing specialized units for the care of dementia or stroke patients, even though they are ill-equipped to handle such special-needs residents; the perception of certain nursing homes that it is cheaper to be out of compliance with federal and state regulations than to take corrective measures; and finally, the lack of access to meaningful, easy-to-understand information for consumers to make informed decisions.²⁰⁰

Quality of care issues were of paramount importance to the Panel, and it made seventeen separate recommendations for improving the quality of care delivered by Delaware nursing homes.²⁰¹ Some of the more significant recommendations of the Panel were:

- (1) increase fines imposed on nursing homes that fail to comply with nursing home regulations;²⁰²
- (2) create rules and regulations to govern the operation of

196. *See id.*

197. *Id.* at 21.

198. *See id.* at 22.

199. *See id.*

200. *Id.* at 7.

201. *See id.* at 25.

202. *Id.* at 24.

specialized care units in nursing homes, such as Alzheimer's units;²⁰³

(3) require the Office of Health Facilities and Licensing and Certification to schedule a meeting with residents and family members upon the completion of a facility's survey process, *i.e.*, after the facility has submitted its response to the state survey agency, to discuss the survey results;²⁰⁴

(4) develop an annual consumer guide to Delaware nursing home care, which should include information on survey deficiencies and Ombudsman's Office complaints for each facility in the state;²⁰⁵

(5) conduct a comprehensive review of existing nursing home regulations to reduce redundancy and to clarify confusing requirements so that nursing home administrators can have a reasonable understanding of what is required under the regulations;²⁰⁶ and

(6) increase staffing in the Office of Health Facilities and Licensing and Certification to enable the agency to carry out more surprise nursing home inspections.²⁰⁷

3. Legislative action

Several of the Panel's recommendations have been implemented through legislation enacted by the Delaware General Assembly.²⁰⁸ Senator Marshall has been the primary sponsor of most of this legislation.²⁰⁹ Specifically, a new oversight division has been created to monitor the long-term care industry in Delaware.²¹⁰ This new division, designated as the Division of Long-term Care Resident Protection, is responsible for licensure and certification surveys of long-term care facilities. It also oversees enforcement actions taken against noncompliant facilities, and is designated by HCFA to perform federal

203. *Id.*

204. *Id.*

205. *Id.* at 25.

206. *Id.*

207. *Id.* at 26.

208. See S. 302, 303, 304, 321, 322, 139th Gen. Assem. (Del. 1998); H.R. 559, 139th Gen. Assem. (Del. 1998).

209. See *id.*

210. See S. 302, 139th Gen. Assem. (Del. 1998).

certification surveys. The new division is intended to coordinate long-term care oversight, and thereby avoid the lack of coordination that was identified as a critical deficiency in the Panel Report.²¹¹

Another Panel recommendation that has been enacted is mandatory criminal background checks and drug screening of applicants for employment in nursing homes.²¹² The law also applies to current nursing home employees who are seeking a promotions.²¹³ Many facilities were voluntarily performing pre-employment drug screening prior to the passage of the drug screening requirement.²¹⁴ However, the law sets forth a list of illegal drugs that specifically must be included in the drug screen.²¹⁵

With regard to criminal background checks, the State Bureau of Investigation conducts the state-funded checks. Fines will be imposed upon employers who fail to conduct criminal background checks and upon applicants who do not cooperate fully with the background check process.²¹⁶ Certain criminal offenses, such as crimes against the elderly and certain convictions for assault, automatically disqualify an applicant from employment in a nursing home.²¹⁷ For other offenses, it is left to the discretion of the nursing home administration to determine whether the individual is an appropriate candidate for employment.²¹⁸

A number of other nursing home reform bills have been passed by the Delaware General Assembly, including:

- Senate Bill 304 (139th General Assembly) – expanding the Statement of Resident's Rights in the State of Delaware to: (1) ensure that residents and their families are able to meaningfully participate in treatment plans and decision-making, and (2) require nursing homes to provide specific information about services provided to residents and relationships with service providers.²¹⁹

211. *See id.*

212. *See* S. 303, 139th Gen. Assem. (Del. 1998), *amended by* S. 13, 140th Gen. Assem. (Del. 1999).

213. *See* S. 13 § 1142, 140th Gen. Assem. (Del. 1998).

214. *See* *Wills v. Demopolis Nursing Home, Inc.*, 336 So.2d 1117 (Ala. 1976).

215. *See* S. 13 § 1142(c), 140th Gen. Assem. (Del. 1998).

216. DEL. CODE ANN. tit. 16, § 1141(b), *amended by* S. 13, 140th Gen. Assem. (1999).

217. *Id.* § 1141(c).

218. *Id.*

219. DEL. CODE ANN. tit. 16, § 1121, *amended by* S. 304, 139th Gen. Assem.

- Senate Bill 322 (139th General Assembly) – rewrote the state’s nursing home licensing statute for the first time since 1953, and strengthened civil monetary penalty provisions.²²⁰
- House Bill 558 (139th General Assembly) – created a hearsay exception to enable the prior statements of now-infirm nursing home residents to be admitted in criminal abuse and neglect prosecutions.²²¹
- Senate Bill 20 (140th General Assembly) – increased mandatory training for CNA’s from 75 hours of instruction to 150 hours, divided evenly between classroom instruction and clinical work. Created a voluntary career ladder to promote CNA retention and professional development.²²²
- Senate Bill 112 (140th General Assembly) – lowered the standard for prosecuting nursing home abuse and neglect cases from “intentional” to “knowing or reckless.” It also added the crime of financial exploitation of the elderly or infirm to the state’s criminal code.²²³

The nursing home industry in Delaware is bracing itself for additional major reforms. Delaware nursing homes have a formidable opponent in Senator Marshall, who has committed himself to “cleaning-up” what he has characterized as a greedy and morally bankrupt industry.²²⁴ One concrete indicator of the new aggressive approach to nursing home oversight in Delaware is the dramatic increase in the number of arrests of nursing home staff members on charges of resident abuse. For example, during the period October 5-7, 1999, three CNAs from three different nursing homes were arrested for allegedly assaulting residents.²²⁵ In each

(1998).

220. DEL. CODE ANN. tit. 16, § 11, *amended by S. 322*, 139th Gen. Assem. (1998).

221. DEL. CODE ANN. tit. 11, § 3516 (1998).

222. DEL. CODE ANN. tit. 24, § 17, *amended by S. 20*, 139th Gen. Assem. (1997).

223. DEL. CODE ANN. tit. 16, § 1131, *amended by S. 112*, 139th Gen. Assem. (1997).

224. MEDICAL SOCIETY OF DELAWARE, LEGISLATIVE ALERTS AND UPDATES, *available at* <http://www.capwiz.com/medsocdel/issues/alert/?alertid=432> (last visited Dec. 18, 2001).

225. Dennis Thompson, Jr., *3 Charged with Abusing Nursing Home Patients*, NEWS J. (Del.), Oct. 14, 1999, at B4.

case, the alleged abuse occurred several months earlier, so the close proximity of arrests is suggestive of a deliberate enforcement effort.²²⁶

In September 2000, a very significant bill introduced by Senator Marshall was signed into law.²²⁷ The law dramatically increases the minimum staffing ratios required in Delaware nursing homes.²²⁸ The bill ran into substantial opposition, primarily due to the projected financial impact to the state—\$10 to \$11 million.²²⁹ The bill also was flawed because it ignored labor market realities. For example, in 2000, Delaware had an unemployment rate of 3.2 percent,²³⁰ and nursing homes already were finding it difficult to meet staffing ratios.²³¹ Despite these very serious drawbacks, the bill was enacted, leaving nursing homes in the unenviable position of needing to find more qualified caregivers at a time when the entire health care industry is competing for a shrinking pool of nurses and CNAs. The fact that the staffing bill was passed over such vigorous opposition is a testimonial to the single-minded tenacity of the reform movement in Delaware. It remains to be seen whether the legislation ultimately will cause more problems than it remedies, as nursing homes struggle with ever-increasing financial pressures and staffing shortages.

E. The Impact of the Balanced Budget Act of 1997

Prior to the passage of the Balanced Budget Act of 1997 (BBA),²³² the nursing home industry enjoyed a period of unprecedented business success and expansion. The expansion was fueled in part by a twenty-five percent increase in spending on nursing facility care during the period 1992 to 1997.²³³ Spending attributable to Medicare more than tripled

226. *See id.*

227. S. 115, 140th Gen. Assem. (Del. 1999).

228. *See id.*

229. *Local Legislative Update*, DEL. HEALTH CARE FACILITIES ASS'N NEWSL. (Del. Health Care Facilities Ass'n, Wilmington, Del.), June 1, 1999, at 2.

230. *See* source cited *supra* note 164.

231. *See id.*

232. Balanced Budget Act of 1997, Pub. L. No. 105-33, 11 Stat. 251 [hereinafter BBA] (healthcare-related provisions codified as amended in scattered sections of 42 U.S.C.).

233. HEALTH CARE FINANCING ADMIN., OFFICE OF THE ACTUARY, NAT'L HEALTH STATISTICS GROUP, TABLE 2, NAT'L HEALTH EXPENDITURES AGGREGATE AND AVERAGE ANNUAL PERCENT CHANGE, BY TYPE OF

during this period, increasing from \$2.8 billion in 1992 to \$10.2 billion in 1997.²³⁴ The increase in Medicare spending coincided with diversification among skilled nursing facilities to meet the needs of patients who were coming into the facilities with increasingly serious and acute health conditions.

One feature of the BBA was to cut \$115 billion from entitlement programs, particularly Medicaid and Medicare, to balance the budget.²³⁵ Of particular relevance to the nursing home industry, the BBA established annual spending caps on therapies and moved skilled nursing facilities from cost-based reimbursement to a prospective payment system (PPS).²³⁶ This payment system uses a fixed per diem rate for reimbursement, and all covered ancillary services, such as physical therapy and speech therapy, are included in the rate.²³⁷ Formerly, the ancillary services were billed separately by the ancillary service providers.

The long-term care industry initially welcomed PPS, but it soon became apparent that the payment rate schedule and inflation adjuster set by HCFA in May 1998 was too low.²³⁸ What has followed has been a cataclysmic decline in the financial stability of the nursing home industry.²³⁹ Several of the largest nursing home companies—Vencor Inc., the nation's largest operator of long-term care facilities, Lenox Healthcare Inc., Mariner Post Acute Network Inc., Integrated Health Services Inc., and Sun Healthcare Group Inc.—as well as several regional chains, were forced to file for bankruptcy protection.²⁴⁰ As noted by

EXPENDITURE (selected calendar years 1960-1999), *available at* <http://www.HCFA.gov/stats/nhe%2Doact/tables/Tables.pdf>.

234. HEALTH CARE FINANCING ADMIN., OFFICE OF THE ACTUARY, NATIONAL HEALTH STATISTICS GROUP, U.S BUREAU OF THE CENSUS, TABLE 7, NURSING HOME CARE EXPENDITURES AGGREGATE AND PER CAPITA AMOUNTS AND PERCENT DISTRIBUTION, BY SOURCE OF FUNDS (selected calendar years 1960-1999), *available at* <http://www.HCFA.gov/stats/nhe%2Doact/Tables/Tables.pdf>.

235. *See* BBA, *supra* note 232.

236. *See* 42 U.S.C. § 1395yy(e)(2)(B) (Supp. 1999).

237. *See id.*

238. *Nursing Home Warns Funding Shortfall Could Compromise Care*, REUTERS MED. NEWS FOR PROFESSIONALS (Jan. 24, 2000), *at* <http://www.reutershealth.com/frame2/arch.html>; *see Integrated Health Services Seeks Protection, Joins List of Nursing Chains in Chapter 11*, 24 DAILY REP. FOR EXEC., Feb. 4, 2000, at A4.

239. *See Integrated Health Services*, *supra* note 238, at A4.

240. *See id.*

Integrated Health Services' CEO, "The dramatic impact of the implementation of the 1997 Balanced Budget Act on our revenues and cash flow seriously [impaired] the company's ability to service our current capital structure."²⁴¹ Unquestionably, federal spending cuts caused severe damage to the stability of the industry.

The rapid decline of the nursing home industry's financial health prompted Congress to take steps to ease the crisis, such as temporarily increasing funding to the nursing home industry and other healthcare providers.²⁴² However, one must question whether such action will merely act as a temporary repair, as money cannot fix all that ails the industry. At the same time that the industry was affected by a dramatic federal spending cut, it also has been targeted by increased regulatory and enforcement initiatives on both the federal and state levels. This necessarily entails an increase in compliance costs. Perhaps even more troubling, however, is the alarming rise in tort litigation that could potentially bankrupt the entire nursing home industry.²⁴³

F. Nursing Home Litigation

Tort lawsuits against nursing homes, as well as the size of verdicts in such cases, are increasing at an alarming pace.²⁴⁴ One need only drive on a major highway today and view the countless roadside advertisements to confirm that nursing homes have become a popular target for plaintiffs' lawyers.²⁴⁵ Prominent billboards encourage individuals who suspect that loved ones have been abused or neglected in nursing homes to consult with an attorney about filing a lawsuit.²⁴⁶ Recent television, radio, and print advertisements have also sought potential plaintiffs to pursue

241. *Integrated Health Services*, *supra* note 171b, at A4-5; see *Vencor Files for Bankruptcy, Employees will be Paid*, PROVIDER, Nov. 1999, at 17 (statement of Edward Kuntz, Vencor's CEO and President "[t]he reorganization also was necessary because of the dramatic changes impacting the long term care industry, most notably decreased Medicare reimbursement.").

242. Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113 App. F, 113 Stat. 1501A-321 (codified as amended at 42 U.S.C. § 1305).

243. *Nursing Home Warns*, *supra* note 238.

244. See Hawryluk, *supra* note 12, at 29.

245. See *id.*

246. Such billboards have been observed along Interstate 95 between Philadelphia, Pennsylvania and Wilmington, Delaware.

litigation against nursing homes.²⁴⁷ In one instance, some 3,500 letters were sent to certified nursing assistants exhorting them to call an abuse hotline.²⁴⁸ The number actually belonged to a law firm that specializes in suits against nursing homes.²⁴⁹

Moreover, plaintiffs' attorneys and resident advocates alike are lobbying for a federal law that guarantees the right to use surveillance cameras in nursing facilities.²⁵⁰ Advocates argue that installing surveillance cameras, popularly referred to as "granny cams," may prevent abuse and neglect of nursing home residents, under the theory that staff members would realize their encounters with residents are being recorded, and control their conduct accordingly.²⁵¹ The proposed law would allow video cameras to be installed with the permission of the nursing home resident or his or her legal representative,²⁵² and nursing home staff would be informed that their interactions with the resident were being recorded.²⁵³ The resident or his or her representative would bear the cost of the camera and installation.²⁵⁴

It should not come as a surprise that among the most vocal advocates for "granny cams" are plaintiffs' lawyers, including Jim Wilkes, a high-profile Florida lawyer who specializes in nursing home cases.²⁵⁵ Although Mr. Wilkes resents the suggestion that the main benefit of cameras in nursing homes would be to provide evidence in court,²⁵⁶ it is beyond question that surveillance cameras could yield critical information in nursing home abuse and neglect cases, especially because the alleged victim is often unable to meaningfully participate in the proceedings due to cognitive limitations.²⁵⁷

Nursing home abuse and neglect cases typically have not been attractive to the plaintiffs' bar, due in large part to the assumption that the

247. Hawryluk, *supra* note 12, at 29.

248. *See id.*

249. *See id.*

250. *See* Deborah Sharp, *Coalition Backs "Granny Cams,"* USA TODAY, Sept. 14, 1999, at A1.

251. *See id.*

252. *See id.*

253. *See id.*

254. *See id.*

255. *See id.*

256. *See id.*

257. *See* FURROW ET AL., *supra* note 13.

characteristics of the average nursing home resident do not lend themselves to large damage awards.²⁵⁸ Usual components of compensatory damages, such as lost wages and out-of-pocket medical expenses, are inapplicable to most nursing home residents, who are long past their working years and whose medical expenses are likely covered by Medicare or Medicaid.²⁵⁹ Causation is also often difficult to establish in nursing home tort cases. In addition to cognitive impairments, nursing home residents are prone to certain conditions, such as bruising and skin tears, which may appear to be the result of abuse or neglect to the untrained eye, when in fact, they are the unfortunate and unavoidable consequences of compromised and deteriorating health status. Nonetheless, three key factors are leading plaintiffs' lawyers to reconsider their reluctance to file tort suits against nursing homes: (1) the enactment of elder abuse laws that permit successful plaintiffs to recover attorneys' fees;²⁶⁰ (2) the lure of huge punitive damage awards;²⁶¹ and (3) a more knowledgeable and resourceful consumer population.²⁶²

Plaintiffs' attorneys, such as Jim Wilkes, argue that the civil justice system is far more effective as a quality improvement mechanism than the regulatory system that oversees nursing homes.²⁶³ According to Mr. Wilkes, the regulatory system is "a joke," and it "needs to be revamped from the bottom to top—for everybody's benefit."²⁶⁴ Mr. Wilkes credits

258. *See id.*

259. *See id.*

260. California, for example, permits a plaintiff to recover attorneys' fees when it is proven that the defendant intentionally or recklessly abused an elderly or infirm adult. CAL. WELF. & INST. CODE § 15657 (West 2001). Likewise, Florida's nursing home residents' rights law allows for private enforcement through lawsuits and recovery of attorneys' fees by successful plaintiffs. FLA. STAT. ANN. § 400.023 (West 1998 & Supp. 2001).

261. *See* Hawryluk, *supra* note 12, at 29. Courts in California, Florida and Texas have seen significant increases in nursing home litigation, which is not surprising, given that huge punitive damage awards available in each of these states. *Id.*

262. For example, federal survey data for every Medicare and Medicaid-certified facility in the country is available online at HCFA's website. Moreover, HCFA publishes a nursing home consumer information guide called "Guide to Choosing a Nursing Home," which provides nursing home patients and their families with information about nursing homes, including residents' rights.

263. *See* Hawryluk, *supra* note 12, at 34.

264. *Id.*

tort litigation with bringing about major improvements in the way nursing homes do business, stating, "I have been told that [as a result of lawsuits] record keeping policies have changed, staffing policies have changed, training has changed, that there's been a new focus among certain corporations on quality-of-life issues rather than simply quality of care."²⁶⁵

The value of tort litigation as a means of resolving nursing home quality of care and quality of life issues is dubious at best. While the specter of a huge damage awards undoubtedly encourages nursing facilities to provide the best possible care, the recent spate of litigation is draining already scarce resources dedicated to patient care and quality of life issues, as nursing homes scurry to fund litigation war chests. While meritorious claims exist, many others are without foundation. Still, given the stakes involved, all claims must be vigorously defended.

Litigation expenses are only part of the problem. The increase in tort litigation has also adversely impacted other nursing home costs. For example, the average annual cost for nursing home malpractice insurance nationwide rose from \$150 per bed in 1992 to \$700 per bed in 1998.²⁶⁶ In Florida, which has 10 percent of the nation's nursing home residents but accounts for 40 percent of nursing home lawsuits,²⁶⁷ the average cost of insuring a nursing home bed has skyrocketed to more than \$6,200 per year.²⁶⁸ Further complicating the situation is the fact that many insurance carriers are dropping their nursing home lines altogether, leaving just a few providers in the market.²⁶⁹ Because nursing homes must carry insurance to operate, insurance companies that continue to underwrite policies for nursing homes can command virtually any premium they wish.²⁷⁰

Other costs associated with the litigious environment in which nursing homes operate today are more difficult to quantify, but are undoubtedly significant. The prevalence of litigation may discourage much-needed caregivers from seeking employment in the nursing home industry. In

265. *Id.*

266. *Id.* at 43.

267. Vickie Chachere, *Florida Nursing Homes Struggle With Lawsuits*, SUNDAY STAR-LEDGER (N.J.), Apr. 23, 2000, Sec. 1 at 25.

268. *Id.*

269. *Id.*

270. *See* Hawryluk, *supra* note 12, at 43 (suggesting that insurance companies will raise costs of the insurance even if it is priced out of the reach of many nursing homes).

addition, existing caregivers and administrators already are feeling the pressure of funding cuts and increased regulatory enforcement, including calls for criminal prosecutions of staff members who are connected to allegations of neglect and abuse. The threat of becoming embroiled in costly civil litigation may be the final straw that drives experienced nursing home personnel out of the industry at a time when the industry can least afford a “brain drain.”

Furthermore, liability in nursing home neglect and abuse lawsuits rarely is open and shut. As noted above, certain conditions that are simply an unfortunate by-product of declining health can be cast as abuse and neglect in the hands of a skillful plaintiff’s attorney. Decubitus ulcers or pressure sores, which are frequent subjects of litigation, fall into this category. While in some cases pressure sores may be indicative of inadequate or incompetent care, they frequently are caused by a complex interplay of many different factors; namely, underlying health conditions, nutritional problems and mobility limitations. The common assumption is that pressure sores result from remaining in one position for too long, which leads to the conclusion that the nursing home’s staff must be at fault. Such preconceived notions, however, may be impossible to overcome, and the consequences can be devastating. For example, a Texas jury recently found that a nursing home resident developed serious pressure sores due to the facility’s negligent treatment.²⁷¹ The jury assessed a staggering \$90 million in punitive damages against the nursing home.²⁷² The court remitted the punitive damage award, but even the reduced sum of almost \$10 million was overwhelming.²⁷³

In another case, a California jury found a nursing home liable for neglect in connection with a resident who, at the time of her death, had several advanced-stage pressure sores.²⁷⁴ The jury awarded the representative of the deceased resident \$165,000 in compensatory damages, and the court determined that the representative was entitled to recover an additional \$185,000 in attorneys’ fees based on the jury’s finding that the nursing home was reckless in its treatment of the resident.²⁷⁵

271. See *Horizon/CMS Healthcare Corp. v. Auld*, 985 S.W.2d 216, 221 (Tex. Ct. App. 1999); see also discussion *supra* pp. 4-5.

272. *Id.* at 221.

273. *Id.*

274. See *Delaney v. Baker*, 971 P.2d 986 (Cal. 1999).

275. *Id.* at 989.

Injuries from falls are another fertile source of lawsuits against nursing homes that have resulted in staggering damage awards. In 1998, an Ohio jury awarded the spouse of a nursing home resident, who died as a result of brain injuries caused by two separate falls, \$168,000 in compensatory damages and punitive damages of \$850,000.²⁷⁶ Falls present a particularly difficult situation for nursing homes. Federal standards direct facilities to minimize the use of restraints and to maximize the physical well-being of residents. The benefits of maintaining and maximizing mobility of nursing home patients are well-documented.²⁷⁷ However, maintaining mobility necessarily entails a heightened risk of falls.

Facilities already must strike a delicate balance between three competing goals: maximizing residents' mobility, avoiding the use of restraints, and protecting residents from fall-related injuries. Adding the threat of fall-related tort lawsuits to the equation may tip the balance in favor of excessive caution, to the disadvantage of nursing home residents, as some facilities may make a conscious decision to err on the side of discouraging and restricting mobility to decrease litigation risk. Although cost-benefit analysis may seem offensive where human beings are involved, the reality is that in the current regulatory environment, it may be cheaper for a nursing home to be cited for failing to maximize residents' well-being than to expose the facility to the risk of a costly and protracted lawsuit. Such a strategy likely would backfire, however, as plaintiff's lawyers would just substitute a violation of resident's rights lawsuit for the fall injury case. It is a no-win situation for nursing homes.

Another troubling aspect of the increase in tort litigation against nursing homes is the fact that each year many claims of abuse and neglect are proven to be completely false. For example, in April 2000, a seventy eight year old female resident of the Neshaminy Manor Nursing Home in Norristown, Pennsylvania told her family that she had been sexually

276. See *Blancett v. Nationwide Care, Inc.*, No. 98-CA-4, 1998 Ohio App. LEXIS 6504, at *2 (Ohio Ct. App. Dec. 16, 1998); see also discussion *supra* pp. 4-5.

277. See, e.g., 42 C.F.R. § 483.25(a)(1)(ii)(1999), which provides:

(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that –

(1) 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

(ii) Transfer and ambulate

assaulted by a male staff member.²⁷⁸ The family immediately reported the assault to the facility's administrator, who, in turn, contacted law enforcement.²⁷⁹ While the investigation was pending, four male staff members were placed on indefinite administrative leave.²⁸⁰ Subsequently, the resident revealed to investigators that she had been feeling lonely and ignored, so she made up the story "to get attention from her family."²⁸¹

Unfortunately, false claims are not uncommon in the nursing home industry.²⁸² Many nursing home residents who suffer from cognitive problems, depression, hostility and/or feelings of loneliness and isolation, complain of being mistreated and abused. Others report having their personal possessions damaged or stolen, when in fact, nothing untoward has occurred. While all complaints must be taken seriously and investigated promptly, the circumstances of the nursing home population must be considered by those who contend that resorting to the tort system is an appropriate means of regulating the nursing home industry.

From all indications, tort litigation against nursing homes will continue to increase at a rapid pace despite numerous negative effects on the industry and residents. Moreover, with the current get-tough attitude of regulators and legislators, it is highly unlikely that there will be much legislative support for statutory limits on damages assessed against nursing homes. Legislators will not act until more nursing home chains file for bankruptcy protection or are forced to close nursing facilities in the legislators' districts. In the meantime, nursing homes must focus their energies on delivering the best possible care. This is the only way that facilities can minimize the likelihood of becoming entangled in potentially devastating tort litigation.

IV. RECOMMENDATIONS

Nursing homes devote significant resources to regulatory compliance

278. Local Evening News (Philadelphia, PA) (NBC television broadcast, Apr. 21, 2000).

279. *Id.*

280. *Id.*

281. *Id.*

282. Even reformers have recognized the problem of false reporting of nursing home complaints. For example, the Delaware nursing home reform included a recommendation "that legislation be enacted which would make intentional false reporting of activity by a nursing home employee a sanctionable offense." Panel Report, *supra* note 155, at 9.

efforts. They do so for two primary reasons: (1) they want to deliver the highest quality care to their residents, and (2) penalties for noncompliance can be significant. Nevertheless, it appears that every day there are reports of egregious abuse and neglect of nursing home residents, which foster calls for regulators to crackdown on the entire nursing home industry. Legislators and regulators are responding to the complaints by pursuing new laws and regulations, instead of focusing on the poor performing facilities. Not only does this approach fail to fix the immediate problems, but it also has shifted the entire emphasis of nursing home regulation to detection and punishment, rather than prevention.

During the past fifteen years, the nursing home industry in this country has been extensively researched and scrutinized. The result has been the creation of a complex system of federal and state laws and regulations that has as its core purpose the protection of nursing home residents.²⁸³ At minimum, every nursing facility in the United States must satisfy state licensure and certification requirements.²⁸⁴ The eighty-six percent of the nation's nursing homes that participate in either Medicare or Medicaid also must satisfy the federal conditions of participation.²⁸⁵ If nursing homes do not meet the applicable regulatory standards, both the federal and state regulatory frameworks include a variety of penalties that may be imposed on the noncompliant facilities.²⁸⁶

Throughout the recent debates regarding nursing home reform, no one has argued that quality of care problems in nursing homes are attributable to a lack of regulation. Rather, on the rare occasions when the focus shifts to problem-solving instead of punishment, the same causes are highlighted: under-funding, staffing shortages, and inept enforcement by regulators charged with the responsibility of overseeing the nursing home industry. These issues are not new. To the contrary, the same problems were identified by the Institute of Medicine (IOM) during its comprehensive study of the nursing home industry in 1986.²⁸⁷ This leads to the inescapable conclusion that the complex regulatory framework created under OBRA 87 and related state laws has not remedied the root causes of deficient practices in nursing homes. Thus, the idea that

283. See QUALITY STANDARDS REPORT, *supra* note 1.

284. See 42 U.S.C. § 1395i-3(g)(1)(A) (1994).

285. See QUALITY STANDARD REPORTS, *supra* note 1.

286. See Omnibus Budget Reconciliation Act of 1987 42 U.S.C. §§ 1395i-1396r (1994).

287. See IOM REPORT, *supra* note 21, at 21.

creating *additional* layers of regulation will lead to improved quality of care is ill-conceived and naive.

If legislators and regulators truly want to foster top quality care in the nation's seventeen thousand nursing homes,²⁸⁸ they must address the systemic problems that plague the nursing home industry. First and foremost, increasing the funding of nursing homes must be made a national priority. All the regulatory mandates in the world will not help nursing home residents in the absence of funding that allows nursing homes to comply with those mandates.

The financial troubles of the nursing home industry are well-documented, as numerous providers have sought protection under the federal bankruptcy laws since 1999, and many others are poised to follow in their footsteps. Critics of the nursing home industry argue that the industry is hiding behind the claim of financial crisis to avoid taking responsibility for deficient practices, and that in fact, money is being funneled to the pockets of facility owners, at the expense of resident care.²⁸⁹

Indeed, the Special Committee on Aging has made it clear that it questions the validity of the contention that the financial problems being experienced by many nursing homes are a function of underfunding.²⁹⁰ In that regard, the Special Committee has commissioned a study of nursing home financing to look at the capital structure of nursing homes, as well as their spending patterns.²⁹¹ It is interesting that the Special Committee's skepticism is flatly contradicted by federal and state regulators, who are unlikely allies of the nursing home industry when it comes to the funding issue.²⁹² HCFA has made a plea for increased funding, stating that it is "making solid progress" in improving nursing home quality, but the lack of funding to implement many of the GAO's recommendations and other improvements limits HCFA's successes.²⁹³

In addition, Delaware's oversight agencies have advocated for funding increases, claiming that the lack of adequate funding inhibits their ability

288. See CALIFORNIA REPORT, *supra* note 7, at 1.

289. See Thompson, *supra* note 9.

290. See *Nursing Home Understaffing*, *supra* note 162, at A32.

291. See *id.* at A33.

292. See *id.*

293. See *Oversight of Nursing Home Inspections Faulty, Uneven, GAO Tells Senate Panel*, DAILY REP. FOR EXEC., Nov. 4, 1999 at A13.

to effectively enforce nursing home regulations.²⁹⁴ Consequently, funding shortfalls are impacting regulators and providers alike. With respect to providers, until there is a commitment on the part of federal and state governments to fund nursing home care at rates commensurate with the true costs of doing business, it is unrealistic to assume that quality problems will be corrected in an effective and lasting manner.

The lack of adequate nursing home funding is closely associated with another systemic problem in the nursing home industry: the difficulty of attracting and retaining competent, compassionate caregivers.²⁹⁵ As noted above, CNAs provide up to eighty percent of direct patient care in nursing homes, yet they are paid similarly to fast-food employees.²⁹⁶ Additional funding is necessary to enable nursing homes to pay CNAs a meaningful wage that recognizes the difficult nature of the work that they perform everyday. Moreover, directing funding increases towards caregivers, rather than enforcement initiatives, would prove to be far more practical.

Staffing issues cannot be solved by money alone. In addition to low pay, several factors contribute to the dearth of CNAs/caregivers in the nursing home industry, including: burn-out, lack of professional development, inadequate training, and high stress caused by enforcement approaches make caregivers feel embattled and unappreciated.²⁹⁷ The nursing home industry must regard CNAs as professional caregivers. Offering career paths, promotional opportunities, continuous training, and meaningful participation on caregiving teams may go a long way toward changing the common perception that a CNA position is a dead-end job. Obviously, the goal of retaining quality caregivers also would be advanced by the adoption of a new attitude among regulators—one that does not reflect a belief that most CNAs are abusive criminals who could not get jobs in any other line of work.²⁹⁸

294. See Panel Report, *supra* note 155, at 19.

295. See *Nursing Home Understaffing*, *supra* note 162, at A33-34.

296. *Id.*

297. *Id.*

298. During an April 19, 2000 meeting of the Health Law Section of the Delaware State Bar Association, Senator Marshall extolled the virtues of the new criminal background check law, noting that the nursing home industry has long been a haven for criminals. Senator Marshall, Remarks at the Meeting of the Delaware State Bar Association Health Law Section (Apr. 19, 2000) (on file with author).

Funding and staffing shortages are relatively easy problems to address in comparison to the issue of inept regulatory oversight. It is submitted that regulators already have adequate regulations and enforcement tools available to them—perhaps even too many. The problem lies in how regulators interpret and apply those regulations and enforcement tools. Rather than focusing on the development of new laws and regulations, the nursing home oversight agencies should devote their resources to: (1) critical self-examination to identify deficiencies in the manner in which their oversight responsibilities are carried out; (2) formulating and implementing action plans to address any identified deficiencies; (3) training survey and enforcement personnel; and (4) sharing their knowledge and expertise with the nursing home industry.²⁹⁹ Training is a particularly important piece of the puzzle, because oversight agencies must understand the regulations in order to effectively enforce them. Here again, money sought for pure enforcement activities would be better directed to training the regulators, who, in turn, could share their knowledge and expertise with the nursing home industry. Regrettably, oversight agencies believe that nursing homes should resolve compliance issues on their own, informing them if they reached the correct conclusions during their surveys.³⁰⁰ This indirect approach is tremendously inefficient, unduly punitive, and most importantly, does not promote the goal of high quality resident care.

Finally, although not yet a systemic problem, it is beyond question that the current increase in tort litigation against nursing homes has the potential to devastate the entire industry. If permitted to continue unchecked, these lawsuits will only further exacerbate the current financial crisis facing the nursing home industry, with an attendant decline in resident services. Decisive steps must be taken promptly to limit the exposure of nursing homes to huge damage awards, which, in many cases, are grossly disproportionate to the nature of the injuries alleged in the suits.

CONCLUSION

Nursing homes in the United States are facing a broad array of challenges that threaten their very existence. For example, federal and state governments are pursuing a variety of legislative and regulatory

299. See *Oversight of Nursing Home*, *supra* note 293, at A13.

300. See *id.*

initiatives that are designed to ferret out and punish nursing homes that fail to meet the standards of participation in federal funding programs, as well as state licensing standards. While no one can argue that providers of substandard care should not be held accountable, the “zero tolerance” approach advocated by many regulators ignores the realities of the nursing home population and essentially treats nursing homes as guarantors of the continued well-being of residents. This is a patently unreasonable position in view of the health status of the typical nursing home resident.

Moreover, the new zero tolerance approach to nursing home enforcement is coming at a time when nursing home funding is being slashed, and eager plaintiffs’ lawyers are targeting the nursing home industry for the next wave of mass tort litigation. These pressures, if left unchecked, may force many nursing homes out of business at a time when the demand for nursing home care is increasing at a dramatic rate. In the absence of a rational approach to nursing home regulation and enforcement, and at least some degree of protection from the potentially devastating consequences of tort litigation, the nursing home industry in this country may be poised to go the way of the dinosaur.

