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An Evaluation of Regulatory Standards and Enforcement Devices in the Nursing Home Industry

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AN EVALUATION OF REGULATORY STANDARDS AND ENFORCEMENT DEVICES IN THE NURSING HOME INDUSTRY

I. INTRODUCTION

SIGNIFICANT PROBLEMS confront the elderly living in the United States: physical ailments of old age, inflationary living expenses, and elevating medical costs. An added concern, however, is the likelihood that a nursing home facility may be in his or her future.[1] While life in such an establishment should be seen as an accommodation satisfying the needs of the elderly, it is more often viewed as an occasion for feelings of despair and abandonment.[2] Indeed, recent investigations conducted by the United States Senate Special Committee on Aging appear to substantiate the fears of the elderly by revealing that, among others, abuse and poor treatment of residents, assaults on human dignity, and unsanitary conditions in nursing home facilities are widespread.[3] In addition, reprisals against those who complain contribute to the sustainment of this intolerable situation.[4] As a result of these and other observations, the Special Committee concluded that over fifty percent of nursing homes in the United States have substandard or life-threatening conditions.[5]

Numerous theories attempt to explain the continuance of this phenomenon. For example, it has been argued that state public assistance formulas contain financial incentives which result in poor care.[6] In addition, it has been found that physicians avoid nursing homes and the treatment of elderly residents[7] and, coupled with the estimation that from eighty to

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[1] *Subcommittee on Long-Term Care of the Senate Special Comm. on Aging, Nursing Home Care in the United States: Failure in Public Policy, Introductory Report*, S. REP. No. 93-1420, 93d Cong., 2d Sess. 15 (1974) (hereinafter cited as *Introductory Report*).

[2] The Subcommittee on Long-Term Care reports that: Nursing home placement is a bitter confirmation of the fears of a lifetime. Seniors fear change and uncertainty; they fear poor care and abuses; loss of health and mobility; and loss of liberty and human dignity. They also fear exhausting their savings and 'going on welfare.' To the average older American, nursing homes have become almost synonymous with death and protracted suffering before death.

Subcommittee on Long-Term Care of the Senate, Special Comm. on Aging, 93d Cong., 2d *Sess.* (1974), *Nursing Home Care in the United States: Failure in Public Policy, Supporting Paper No.* 1, *The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy XI* (Comm. Print 1974) (hereinafter cited as *Supporting Paper No.* 1).

[3] *Id.* at 169-70, 196-99, 173-76.

[4] *Id.* at 191-93.

[5] *Id.* at 205-09.

[6] *See generally, Subcommittee on Long-Term Care of the Senate Special Comm. on Aging*, 94th Cong., 1st Sess., *Nursing Home Care in the United States: Failure in Public Policy, Supporting Paper No.* 9, *Profits and the Nursing Home: Incentives in Favor of Poor Care* (Comm. Print 1975).

[7] *See generally, Subcommittee on Long-Term Care of the Senate Special Comm. on Aging*, 94th Cong., 1st Sess., *Nursing Home Care in the United States: Failure in Public Policy, Supporting Paper No.* 3, *Doctors in Nursing Homes: The Shunned Responsibility* (Comm. Print 1975).

ninety percent of patient care in nursing homes is given by untrained aides and orderlies,[8] it is apparent that an instant panacea for nursing home problems is highly unlikely. However, the ultimate explanation for their persistance appears to lie with insufficient regulatory standards and enforcement devices.[9]

This comment will encompass three areas. First, the economic structure of the nursing home industry and existing problems will be described. Second, current regulatory standards and enforcement devices which have been developed by federal agencies to deal with these problems will be explored. Third, the recent enactment of Ohio legislation which not only confers various rights upon nursing home residents but also seeks to eliminate institutional abuse through the implementation of adaptive enforcement devices, will be examined. In addition, the Ohio nursing home "bill of rights" will be looked at in conjunction with similar legislation passed in New York.

II. CHARACTERISTICS OF THE NURSING HOME INDUSTRY

A. *Terminology*

The word "nursing home" is normally construed broadly to encompass all types of nursing care and services. However, states like Ohio often distinguish a nursing home, rest home, and home for the aging according to the types of care and services which they render.[10] Moreover, federal agencies have defined two levels of nursing facilities for purposes of involvement in the Medicare and Medicaid programs. The first is the skilled nursing facility (SNF) which provides adept nursing care and related services as

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[8] *See generally, Subcommittee on Long-Term Care of the Senate Special Comm. on Aging,* 94th Cong., 1st Sess., *Nursing Home Care in the United States: Failure in Public Policy, Supporting Paper No. 4, Nursing in Nursing Homes: The Heavy Burden (The Reliance on Untrained and Unlicensed Personnel)* (Comm. Print 1975).

[9] *See text accompanying* notes 75-76 *infra.*

[10] For example, nursing home is defined by Ohio statute as "a home used for the reception and care of individuals who by reason of illness or physical or mental impairment require personal assistance but not skilled nursing care. A nursing home is licensed to provide personal assistance and skilled nursing care." OHIO REV. CODE ANN. § 3721.01(F) (Page Supp. 1979). On the other hand, rest home means "a home which provides personal assistance for six or more individuals who are dependent on the services of others by reason of age or physical or mental impairment but who do not require skilled nursing care. A rest home is licensed to provide only accommodations and personal assistance and may not admit individuals requiring skilled nursing care." OHIO REV. CODE ANN. § 3721.01(G) (Page Supp. 1979). Moreover, home for the aging means a home which provides:

> (1) Personal assistance for six or more individuals who are dependent on the services of others by reason of age and physical or mental impairment, but who do not require skilled nursing care.
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> (2) Personal assistance and skilled nursing care for three or more individuals. The part or unit of the home for the aging that provides personal assistance is licensed as a rest home. The part or unit that provides skilled nursing care is licensed as a nursing home.

OHIO REV. CODE ANN. § 3721.01 (H) (Page Supp. 1979).

well as rehabilitative benefits to the resident.[11] The emphasis in this type of facility is upon medical supervision to deal with the critically ill or convalescent patient.

On the other hand, an intermediate care facility (ICF) provides a less intensive level of service.[12] This type of institution is primarily designed to accommodate those too ill to return to their private living arrangements but not ill enough to require skilled nursing care. However, like the SNF, the ICF has rehabilitative therapy and preventative health programs.

Generally, all types of facilities are subject to state regulations in terms of licensing requirements, but the degree to which the SNF and ICF must comply with federal fire, health, and safety regulations depends on whether the facility decides to participate in federal Medicare and Medicaid programs.

B. *Nursing Home Funding*

Title XVIII of the Social Security Act, otherwise known as Medicare, was the first national health insurance program for the elderly.[13] Part A of the Act benefits the majority of those age sixty-five or older, but covers only a limited range of services.[14] For example, when a Medicare recipient becomes ill, benefits will help cover not only hospital care but also SNF care for a maximum period of one hundred consecutive days.[15] Medicare will reimburse the SNF for both the direct cost of care to the individual as well as the reasonable cost of items or services which relate to patient care.

Since Medicare coverage is limited and applies to only those services provided by an SNF it is Medicaid, a federal grant-in-aid program administered by the Department of Health, Education, and Welfare (HEW), which provides the greatest relief for those elderly persons in nursing homes who cannot afford to pay the costs of institutional care. It has been estimated that Medicaid pays over one-half of all nursing home costs in the United States.[16]

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[11] 42 U.S.C. § 1395x(jj) (1974).

[12] 93 Fed. Reg. 2221 (1974).

[13] 42 U.S.C. § 1395 *et. seq.* (1974).

[14] 42 U.S.C. § 1395c - 1395i(2) (1974). Part B of the Medicare program provides optional medical insurance for those 65 or older who pay a monthly premium. Eligibility for Part A benefits does not exclude involvement in the Part B program. 42 U.S.C. § 1395i(2) (1974).

[15] 42 U.S.C. § 1395d(a)(2) (1974). However, to receive Medicare benefits in a nursing home, a patient must have been hospitalized at least 3 days, must have a physician certify that there is an actual need for intensive nursing care, must enter an SNF within 14 days after leaving the hospital and, in addition, must acknowledge that care is needed for the same condition which existed while hospitalized. 42 U.S.C. § 1395x(i) (1974).

[16] *See Supporting Paper No.* 1, *supra* note 2, at XI. As opposed to paying 5% of nursing home costs in Ohio in the form of Medicare monies the federal government, for example, provides Medicaid coverage for approximately half of the nursing home patients in Ohio. HOW TO SELECT AN OHIO NURSING HOME, OHIO COMMISSION ON AGING, 8 (March, 1977).

Medicaid, promulgated under Title XIX of the Social Security Act, provides that medical care be given to all indigent persons regardless of age.[17] States which elect to participate in the program must submit a plan to HEW which outlines a medical care scheme for those categories of indigents who would qualify under the program.[18] The plan must also designate a state agency which is responsible for Medicaid administration.[19] After approval by HEW, the amount of the medical care cost which the federal government will pay is determined by the per capita income of that particular state and will range anywhere from fifty to eighty-three percent with the states and localities sharing the remainder of the cost.[20] Medicaid coverage includes not only medical, rehabilitative, and related services but, as opposed to Medicare, also provides for unlimited nursing home care in both SNF's and ICF's.[21]

C. *Existing Problems in the Nursing Home Industry*

Despite rising public concern and rising public funds in the form of Medicare and Medicaid expenditures, the problem of assuring quality care in the nursing home industry persists.[22]

The inadequacy of proper medical attention given to nursing home residents invades, to some extent, even the best institutions. Whether it is in the form of infrequent or nonexistent visits by physicians,[23] the use of untrained personnel in performing skilled medical tasks,[24] unsanitary conditions which may cause or agitate virulent infections,[25] or the preparation of unwholesome, spoiled foods,[26] the health of the nursing home resident may be overtly jeopardized.

However, additional practices may exist in the nursing facility that, while not as manifest as the aforementioned, may have a greater damaging effect on the dignity of the resident and may result in extraordinary physical

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[17] 42 U.S.C. § 1396 *et. seq.* (1974). Normally, for qualification as a Medicaid recipient, the local welfare department will determine eligibility according to income limits (determined by monthly income) and poverty requirements (amount in savings accounts and property assets). For those residents who enter the nursing home as private paying patients, it is Medicaid funding which will be sought after private funds have been exhausted. How TO SELECT AN OHIO NURSING HOME, *supra* note 16, at 8.

[18] 42 U.S.C. § 1396a (1974).

[19] For example, in Ohio Medicaid is administered by the Ohio Department of Public Welfare.

[20] 42 U.S.C. § 1396b (1974).

[21] *See generally,* 42 U.S.C. § 1396d(a)(1)-(17) (1974).

[22] The Ohio Nursing Home Commission, in a recent report, concluded that Ohio "fails to ensure that nursing homes meet even minimum health and safety standards, much less that they deliver uniformly high-quality long-term care." Akron Beacon Journal, January 20, 1980, at C6, col. 1.

[23] *See text* & note 7 *supra.*

[24] *See text* & note 8 *supra.*

[25] *See Supporting Paper No.* 1, *supra* note 2, at 173.

[26] *Id.* at 176-80.

and psychological harm given the advanced age of most nursing home residents.[27] For example, the resident may be a victim of both verbal abuse and deliberate physical injury. Instances of this type of misconduct usually arise because of inadequate supervision and training of nursing home employees.[28]

Consequently, the U.S. Senate Special Committee on Aging received numerous complaints about residents who were given very hot or very cold showers or baths as punishment as well as others who remained in the bath for hours with the door open.[29] In essence, the possible infringement of rights which an individual encounters when entering a nursing home may include the denial of the simple right to have a door kept closed to the loss of more significant rights such as the inability to practice religious exercises, restricted communications with family and friends, the loss of the right to choose a physician or pharmacist, and the inability to voice grievances without fear of reprisal.

In addition, recurring instances of patient sedation and the use of unauthorized or improper restraints for staff convenience have been discovered.[30] The use of such practices could result in dire consequences for the resident. For example, an excess number of drugs may be administered as restraints without physician authorization. Similarly, improper physical restraints may hinder evacuation attempts in the event of a fire.

Additional evidence reveals that residents may be victims of theft and misappropriation of their property.[31] This is especially distressing to the resident when items of necessity, such as eyeglasses, are either stolen or lost and not replaced. Also, patients may not receive personal expense money which is allotted to them under the Medicaid program.[32]

"Profiteering" also exists in the nursing home industry.[33] For example, an administrator of a home may claim an unreasonable economic gain by setting exorbitant prices for private paying patients, charging these patients for items which they never receive or, in the case of all residents whether private paying or not, cutting expenses to such an extent that the resident is harmed. For instance, in an effort to decrease expenses the least number of staff members necessary may be employed, food may be rationed, or sanitary precautions may be compromised in favor of eliminat-

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[27] It is estimated by the Senate Special Comm. on Aging that the average age of the nursing home resident is 82. *See Introductory Report, supra* note 1, at 16.

[28] *See Supporting Paper No.* 1, *supra* note 2, at 169-73.

[29] *Id.* at 196.

[30] *Id.* at 188-91.

[31] *Id.* at 180-83.

[32] In Ohio, Medicaid patients receive $25.00 per month as personal expense money. HOW TO SELECT AN OHIO NURSING HOME, *supra* note 16, at 8 (March, 1977).

[33] *See Supporting Paper No.* 1, *supra* note 2, at 199-204.

ing added costs. Abuses of this nature can only be controlled through effective regulatory standards and strict enforcement devices.

III. THE RESPONSE OF THE FEDERAL GOVERNMENT TO NURSING HOME PROBLEMS

A. *Regulatory Standards*

To cope with the numerous problems found in the nursing home industry, standards concerning both nursing home construction and patient care have been instituted by means of federal and state statutes and regulations.

The required degree of compliance with federal fire, health, and safety regulations depends on whether a facility is classified as an SNF or ICF. An SNF, which may receive either Medicare or Medicaid funds or both, must meet federal regulatory standards in such areas as overall compliance with federal, state, and local laws,[34] the development of an effective governing body with the requisite legal authority for the operation of the nursing facility,[35] patient care in the form of medical direction as well as qualified nursing personnel to meet the needs of the resident,[36] specialized nursing home services which affect the well-being of the patient,[37] disclosure of vital information affecting the welfare of the resident,[38] and adequate recordkeeping devices.[39]

Facility standards relating to an ICF which receives Medicaid funding are comparable to the standards outlined for an SNF. For example, the following standards must be complied with by the ICF: stringent administration policies[40] demanding that there be an adequate staff to carry out the policies, responsibilities, and programs of the ICF as well as a provision stating that an overall plan of care be developed for each resident,[41] adequate fire protection by compliance with Life Safety Code (LSC) regulations,[42] environmental and sanitation standards in such areas as resident living quarters and bathroom facilities,[43] meal service and planning,[44] medi-

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[34] 42 C.F.R. § 405.1120 (1978).
[35] *Id.* § 405.1121.
[36] *Id.* § 405.1122-.1124.
[37] *Id.* § 405.1125-.1131, .1134-.1136.
[38] *Id.* § 405.1133.
[39] *Id.* § 405.1132.
[40] *Id.* § 442.301-.302.
[41] *Id.* § 442.319.
[42] *Id.* § 442.321-.323. LSC (Life Safety Code) refers to a scheme of fire and safety requirements promulgated by the National Fire Protection Association.
[43] *Id.* § 442.324-.330.
[44] *Id.* § 442.331-.332.

cations,[45] health services,[46] and additional services which include rehabilitative and social activities.[47]

A vital part of both SNF and ICF federal regulations provides that the governing facility develop a bill of patient rights. Although separate rights' provisions are outlined for both SNF's[48] and ICF's[49] to follow in developing their respective policies, the federal regulations list basic rights deemed to be of special significance to the nursing home resident who, it has been seen, is likely to be exposed to substantial abuse. For example, the policies developed by either the SNF or ICF must provide that the resident have knowledge of the services available in the facility as well as notice of the charges if these services are used.[50] Moreover, the resident must not only be fully informed of his medical condition and the right to participate in planning his care, but he must be given the opportunity to refuse treatment and involvement in experimental research.[51] Also, the resident, except where medically advisable or in the case of an emergency, is not to be subject to physical or chemical restraints.[52] Additional rights given to the resident include: the right to manage his or her personal financial matters,[53] the right not to be transferred or discharged unless for valid reasons,[54] the right to privacy and to treatment with consideration, respect, and dignity,[55] the right to participate in social, religious, and community group activities,[56] the right to free communication,[57] and the right to use personal possessions.[58] In order to insure compliance with these rights, the resident is given the opportunity to submit complaints free from reprisal.[59]

The aforementioned "conditions of participation" must be adhered to by the facility before the SNF or ICF is certified and, hence, eligible for either Medicare or Medicaid reimbursement.[60] A valid "provider agreement," issued to the facility at the time it joins the Medicare or Medicaid program, demonstrates compliance with the conditions. Since the initial

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[45] *Id.* § 442.333-.337.
[46] *Id.* § 442.338-.342.
[47] *Id.* § 442.343-.346.
[48] *Id.* § 405.1121(k).
[49] *Id.* § 442.404.
[50] *Id.* § 405.1121(k)(1)(2); § 442.311(a).
[51] *Id.* § 405.1121(k)(3); § 442.311(b).
[52] *Id.* § 405.1121(k)(7); § 442.311(f).
[53] *Id.* § 405.1121(k)(6); § 442.311(c).
[54] *Id.* § 405.1121(k)(4); § 442.311(c).
[55] *Id.* § 405.1121(k)(9); § 442.311(g).
[56] *Id.* § 405.1121(k)(12); § 442.311(j).
[57] *Id.* § 405.1121(k)(11); § 442.311(i).
[58] *Id.* § 405.1121(k)(13); § 442.311(k).
[59] *Id.* § 405.1121(k)(5); § 442.311(d).
[60] U.S.C. § 1395aa (1974); 42 U.S.C. § 1396a(a)(5) (1974).

provider agreement is valid for a one-year period[61] it must be renewed annually. Responsibility for inspection and enforcement of federal regulations which result in the initial certification or renewal of the provider agreement, however, has been delegated to the states. As will be subsequently discussed, the degree to which the federal regulations are effective will depend on the fervor with which the delegated state agency acts.[62]

In sum, notwithstanding that the federal government has outlined provisions concerning both regulatory standards and patient rights' policies to be met by those nursing homes receiving Medicare and Medicaid funding, the following questions remain: What enforcement mechanisms exist to insure that both the standards as well as the patient rights' policies are adequately enforced? In addition, to what extent, if any, have these enforcement procedures been successful?

It is to be emphasized that states, such as Ohio, have devised their own regulatory standards and provisions for nursing home patients' rights, both of which contain a similar listing of patient rights found in the federal scheme but different enforcement devices. At this juncture, however, it is those procedures which have been employed by the federal government to insure compliance with federal regulations which will be examined. Consequently, the extent to which the federal regulatory standards and enforcement devices have or have not been successful as opposed to those enacted by the states will be explored.

B. *Enforcement Devices*

The most effective procedure which the federal government has available in the enforcement of its regulatory standards is the decertification and termination of its provider agreement with the nursing facility. As noted previously, however, the federal government has delegated enforcement of these program standards to the state. As a result, the state agency conducts surveys to insure compliance with the federal standards.

The fervor with which state enforcement agencies act to implement these standards has been questioned.[63] For example, the U.S. Senate Special Committee on Aging determined that:

> There is no direct Federal enforcement of these (regulations) and previous Federal standards. Enforcement is left almost entirely to the States. A few do a good job, but most do not. In fact, the enforcement

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[61] 42 C.F.R. § 405.1904 (1978).

[62] *See supra* note 27.

[63] *See* Comment, *Regulation of Nursing Homes - Adequate Protection for the Nation's Elderly?*, 8 ST. MARY'S L.J. 309, 320-22 (1976); Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304, 324-29 (1975); Murray & Glassberg, *Long-Term Health Care for the Elderly: The Challenge of the Next Decade*, 39 ALBANY L. REV. 617, 645-46 (1975).

system has been characterized as scandalous, ineffective, and, in some cases, almost nonexistent.[64]

Perhaps the main reason for this criticism has been the lack of effective manpower which exists on the state level to adequately survey the nursing home. For example, the Ohio Department of Health, which is responsible for Medicare and Medicaid inspections, conducts its surveys by the use of a registered nurse and a sanitarian.[65] It is questionable whether all conditions of the nursing home, especially those aspects concerning adequate patient care, can be properly enforced without physician or medical expert evaluation.

In addition, it has been charged that inspections are infrequent, cursory, and ritualistic, and that concentration centers on the physical aspects of the facility rather than patient care.[66] Although the practice of sending advance notice to the institution forewarning it of the inspection has been common, this practice now seems to be changing.[67]

On the other hand, the inadequacy of state inspection teams may arguably be only a reflection of the ambiguous regulatory standards which they are directed to enforce. For example:

> The ICF must have staff on duty 24 hours a day sufficient in number and qualifications to carry out the policies, responsibilities, and programs of the ICF.[68]
>
> Each resident must be given privacy during treatment and care of personal needs.[69]

Such vague regulatory standards as these not only invite inspectors to use their subjective judgment in determining whether a violation exists, but also may be the cause of allowing especially ambiguous standards to be entirely ignored. This problem is particularly acute in the area of patient rights' policies where the broad rights given to the resident are especially difficult to police. Despite provisions which mandate that the ICF receive complaints and recommendations from its residents[70] and that the SNF develop a patient care policy which would insure the personal and property rights of the patient,[71] no federal private cause of action is expressly con-

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[64] *See Supporting Paper No.* 1, *supra* note 2, at XII.

[65] HOW TO SELECT AN OHIO NURSING HOME, *supra* note 16, at 10 (March, 1977). It should be noted that the Ohio Department of Health has been criticized by the Ohio Nursing Home Commission: "The chief responsibility for this failure [of the nursing home to meet minimum health and safety standards] rests with the Ohio Department of Health." Akron Beacon Journal, January 20, 1980, at C6, col. 1.

[66] *See Introductory Report, supra* note 1, at 76-91.

[67] N.Y. PUB. HEALTH LAW, art. 28, § 2803 (McKinney, 1977); MICH. COMP. LAWS ANN. § 331.653(e)(2) (1974); CAL. HEALTH & SAFETY CODE § 1421 (West 1973).

[68] 42 C.F.R. § 442.302 (1978).

[69] *Id.* § 442.404(g)(2).

[70] *Id.* § 442.309.

[71] *Id.* § 405.1121.

ferred on the resident to enforce his rights. However, given the existence of both vague regulatory standards and inadequate inspection teams, the absence of a private cause of action further serves to question the usefulness of the rights given to the resident.[72]

Circumstances may also exist which leave the state inspection agency with no viable alternative but to tolerate inferior conditions. First of all, there may be a shortage of facilities in that particular geographical area and, hence, to close the institution may result in some elderly residents being without adequate accommodation. On the other hand, if facilities are available and geographically convenient, the closing of an institution would entail the transfer of elderly residents to new surroundings which may cause damage to their health.[73] Secondly, the extent to which the Secretary of HEW or the state agency can summarily terminate a provider agreement with the nursing facility is uncertain. Recent case law suggests that the institution is entitled to a hearing when the decision is made not to renew the provider agreement.[74] The continuation of this trend, however, can only result in protracted litigation and, to the extent that the inferior facility remains open, the nursing home resident will suffer.

IV. THE RESPONSE OF THE STATES TO NURSING HOME PROBLEMS

A. *Generally*

States have traditionally employed the same types of enforcement devices which exist on the federal level. Basically, states regulate the nursing home by issuing a license which signifies that it has complied with state laws and regulations. For example, in Ohio the director of the Ohio Department of Health has been given authority to establish procedures to be followed in inspecting and licensing nursing facilities.[75] In addition, an inspection of the home is required both prior to the issuance of the license as well as annually thereafter[76] and, like termination of the provider agree-

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[72] One commentator argues, however, that an implied cause of action could be sought for a violation of recognized patient rights under the pretense that the resident has been deprived of his constitutional or statutory rights under color of state law. Comment, *Regulation of Nursing Homes - Adequate Protection for the Nation's Elderly?, supra* note 63, at 323-24.

[73] Brown, *supra* note 63, at 334. *See* Hitov, *Transfer Trauma: Its Impact on the Elderly,* 8 CLEARINGHOUSE REVIEW 846 (April 1975).

[74] Maxwell v. Wyman, 458 F.2d 1146 (2d Cir. 1972) (plaintiff-nursing home operators entitled to a preliminary injunction restraining the termination of medical reimbursement to plaintiffs until a hearing had been conducted concerning alleged facility violations); Paramount Convalescent Center, Inc. v. Department of Health Care Services, 43 Cal. App. 3d 35, 117 Cal. Rptr. 321 (Ct. App. 1974) (petitioner-nursing home must be granted a hearing before a decision is made to terminate the provider agreement with petitioner); *but see* Shady Acres Nursing Home v. Canary, 39 Ohio App. 2d 47, 316 N.E.2d 481 (Ct. App. Franklin Cty. 1973) (no hearing is required with regard to a termination of rights ordered after provider agreement has expired).

[75] OHIO REV. CODE ANN. § 3721.02 (Page Supp. 1979).

[76] *Id.*

ment on the federal level, the appropriate state agency is able to initiate proceedings to suspend or revoke the state license. In fact, in some states this may be the only device available to control substandard facilities. Efforts to suspend or revoke the state license, however, confront the same difficulties which exist when the state agency attempts to decertify a federally-funded Medicare or Medicaid facility: infrequent inspections, inadequate inspection teams, vague regulatory standards, and hesitancy to close a facility due to the absence of adequate alternative institutions.

B. *Ohio*

In an attempt to correct these ills, Ohio has chosen to enact legislation which seeks to outline a number of distinct rights which the resident ought to receive as well as adaptive enforcement procedures.[77] The set of rights included in the Ohio legislation is more comprehensive and detailed than those outlined for SNF's and ICF's by the federal government. For instance, selected additional rights found in the Ohio legislation are: the right to a safe and clean living environment pursuant to Titles XVIII and XIX of the Social Security Act and applicable state laws and regulations prescribed by the public health council,[78] the right to withhold payment for physician visitation if the physician did not visit the resident,[79] and the right of the resident or person paying for the care to examine or receive a bill at least monthly from the facility that itemizes charges not included in the basic rates.[80] In order to insure that the resident is aware of his rights a copy of them must be given, with written acknowledgement, to the resident.[81] Copies are also required to be distributed to the staff and posted prominently within the facility.[82]

To enforce these measures, Ohio requires that the administrator of the home not only establish and annually review written policies regarding the applicability and implementation of residents' rights but, in addition, he or she must also establish a grievance committee for review of residents' complaints.[83] The grievance committee is composed chiefly of staff, residents, and outside representatives.

If a resident feels that one or more rights have been violated, a grievance may be filed with the committee. If the committee determines that a violation has occurred it is directed to notify the administrator of the home

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[77] *See, e.g., id.* §§ 3721.10-.18, .99.
[78] *Id.* § 3721.13(A)(1).
[79] *Id.* § 3721.13(A)(9).
[80] *Id.* § 3721.13(A)(25).
[81] *Id.* § 3721.12(A)(3)(a), (B).
[82] *Id.* §§ 3721.12(3)(c), 3721.12(C).
[83] *Id.* § 3721.12(A)(1); 3721.12(A)(2).

who is given ten days to correct the matter. A number of appeals exist in the event the administrator chooses to ignore the problem.[84]

This additional alternative enforcement device in the form of the grievance committee is essential in vindicating patient rights. It is not only easily accessible to the resident but it also brings the alleged violation to the attention of the nursing home administrator in a formal, yet inexpensive manner. The Ohio legislation is also significant in that it lists substantial fines as sanctions against non-compliance by the facility. For example, it is provided that a maximum $1,000 fine will result if any retaliatory measure is employed against the complaining resident.[85]

The most warranted provision in the Ohio legislation, however, gives the resident whose rights are violated a private cause of action against any person or facility committing such violation.[86] The Ohio bill of rights permits actual and punitive damages as well as the award of reasonable attorney fees to the prevailing party.[87]

The allowance of a private cause of action, absent in the federal provisions regarding SNF's and ICF's, adds a much needed weapon to an already existing arsenal of protection for the resident. For example, it has been established that the nursing facility is liable on a tort basis for injuries sustained by the negligent or intentional actions of the facility.[88] In addition, the resident may also bring an action in contract.[89]

However, how successful this effort at more private involvement in public enforcement of nursing homes has been is questionable. Granted, there is a need for alternative enforcement devices to help eliminate nursing home abuse, but it must be recognized that the majority of nursing home residents are in a vulnerable position. They often suffer from physical or mental ailments and, although they may be aware of their right to

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[84] *See id.* § 3721.17.

[85] *Id.* § 3721.17(G)(3).

[86] *Id.* § 3721.17(I).

[87] *Id.*

[88] A nursing home is liable for the breach of duty it owes in treating and caring for its patients: Dusine v. Golden Shores Convalescent Center, Inc., 249 So.2d 40 (Fla. Ct. App. 1971) (evidence of lack of care demands that question of whether a nursing home was negligent go to the jury); Lathan v. Murrah, Inc., 121 Ga. App. 554, 174 S.E.2d 269 (1970) (evidence of patient neglect makes it essential that jury question arise as to the question of negligence). In addition, a nursing home is liable for the intentional actions of its employees: Big Town Nursing Home, Inc., v. Newman, 461 S.W.2d 195 (Tex. Civ. App. 1970) (plaintiff-nursing home resident entitled to exemplary damages for false imprisonment).

[89] For example, a resident may bring suit on the grounds that he or she is a third party beneficiary of the provider agreement between the nursing home and the federal government so that if the care provided falls below applicable federal standards, the resident is able to sue.

It is also possible that a cause of action exists on breach of implied warranty or illegal contract grounds.

bring a grievance before a committee or advance a private civil litigation suit, there may be a substantial hesitance on their or others' part to institute any action for fear of antagonizing those who care for the resident. Therefore, the bulk of enforcement responsibility should continue to lie with state regulatory agencies. To this extent, efforts by the states to encourage well-run health care facilities should be directed primarily toward strengthening state licensing and inspection requirements so that the basic root of nursing home ills are effectively uncovered and dealt with before it becomes the responsibility of the resident to cope with subsequent abuse. The Ohio legislation, while it adequately meets its goal of giving the resident certain rights with appropriate mechanisms to enforce them, falls short of strengthening its licensing and inspection requirements. Indeed, it is in this latter area where any reformation of nursing home systems should begin.[90]

C. *New York*

New York, perhaps due to its long-standing reputation of having an inefficient and corrupt nursing home industry, has recently enacted a sweeping reform package which not only provides the resident with a private cause of action in the event that his or her rights have been violated, but also includes relatively severe licensing and inspection requirements.[91]

Essentially, the New York legislation requires that before a nursing facility is given permission to receive its license and perform operations, it must succeed in meeting the following requirements: compliance with a detailed checklist of nursing home matters developed by the commissioner of the department of health,[92] in-depth accounts of financial and administrative data,[93] a listing of the patient bill of rights and acknowledgement of

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[90] Two proposed legislative bills which would significantly impact on present Ohio nursing home law are, at the time of this publication, pending in committee hearings. Basically, H.R. REP. No. 670 provides vigorous pre-licensing requirements for those applicants who desire to open a nursing home. It also upgrades present inspection standards by mandating a training program for inspectors, and it strengthens both the qualifications and on-the-job availability of vital personnel such as medical directors, dietary supervisors, and daily employees. In addition, it provides for a system of classifying violations in order to more readily identify nursing home hazards. This system would play a key role for the proposed Nursing Home Advisory Board which would devise a rating scale for each nursing home based on the number and class of violations committed by the facility. H. Con. Reg. 670, 113th Ohio Gen. Ass., 2d Sess. (1980).
Essentially, S. Res. 200 places key responsibility in a nursing home inspector general and his staff. They must adhere to strict requirements in issuing licenses to new operators, inspections, and maintaining uniform rules regarding physical structure and personnel requirements of a home. The legislation, however, is unique in two areas. First, it provides for a nursing home residents' ombudsman who would receive and deal with complaints of violations. Second, it permits the court, upon proper showing, to appoint a health care receiver who would take possession and use of the facility while reported violations are being corrected. Am. S.B. 200, 113th Ohio Gen. Ass., 2d Sess. (1980).

[91] N.Y. PUB. HEALTH LAW §§ 2800-2813 (McKinney 1977).

[92] *Id.* § 2803(1)(C).

[93] *Id.* § 2805-e.

these rights by the resident,[94] and a disclosure of the character, competence, and standing in the community of those who propose to open the facility.[95]

If the facility receives its license, the New York legislation attempts to encourage the institution to maintain a high level of competency by developing a state reimbursement rate formula for the nursing home whereby each facility would receive payments in accordance with an on-site audit of its financial records[96] and an evaluation of its facilities by objective criteria developed by the commissioner of the health department.[97] This reimbursement formula attempts to relate the amount of expenditure given to the nursing home with the type of program and patient care policy which the nursing home conducts. In a correlative effort to insure compliance with regulations, the New York legislation also provides for stringent inspection requirements. The commissioner, or those designated by him, must conduct two or more annual inspections of each residential health care facility to determine the adequacy of care being rendered.[98] At least one of these visits is required to be unannounced. Results of the detailed inspections, including deficiencies or areas of significantly high care, are to be posted within the residential health care facilitiy.[99]

If violations have been established, a number of alternative actions are available. First, like the Ohio legislation, a private cause of action is given to the resident.[100] Compensatory and punitive damages may also be sought.[101] However, the New York legislation goes further and authorizes the resident to seek either injunctive or declaratory relief[102] or join with other residents and maintain a class action.[103]

In addition, the New York Planning Council is required to establish a system of penalties of up to $1,000 per day for continuing violations of rules and regulations if a nursing facility fails to correct deficiencies within thirty days.[104]

However, the most innovative provision of the New York legislation requires that, although no nursing home operating certificate can be re-

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[94] *Id.* § 2803-c.

[95] *Id.* § 2801-a(3)(b). Essentially, this provision states that if it is disclosed that an individual connected with the proposed facility has been associated with an inferior health care facility within a prior ten-year period, certification may be denied.

[96] *Id.* § 2808.

[97] *Id.*

[98] *Id.* § 2803(1)(a).

[99] *Id.* § 2896-h(1)(a).

[100] *Id.* § 2801-d(1).

[101] *Id.* § 2801-d(2).

[102] *Id.* § 2801-c.

[103] *Id.* § 2801-d(4).

[104] *Id.* § 2803(6), (7).

voked or suspended without a hearing, if it is determined that there exists a condition or practice which poses imminent danger to the health or safety of a resident the certificate may be temporarily suspended without a hearing for a period of up to thirty days.[105] Once the operating certificate is revoked, the commissioner or his designee is able to be appointed receiver and take charge of the facility in order to protect the residents and insure that compliance is met without terminating vital services.

The New York legislation, both comprehensive and innovative in many respects, seeks to eliminate the creation of those facilities which would likely develop deficient conditions by incipiently investigating and questioning those who seek to construct a facility for the aged. All legislation should be directed to this primary level in order to help eliminate problem nursing homes before they have the opportunity to materialize. In addition, by creating more stringent inspection policies more deficiencies can be detected and, augmented by those devices given to the resident to protect his or her rights, greater surveillance of the nursing home industry is possible.

V. CONCLUSION

The nursing home industry in many states is presently in a stage of transformation. After years of public neglect, legislation is being enacted which attempts to deal with ineffective regulatory standards and inadequate enforcement devices. For example, the Ohio legislation exemplifies this trend by giving to the resident a bill of rights with adequate enforcement devices in the form of a grievance committee and a private cause of action. Yet, Ohio does not reach as far as New York in developing additional procedures which result in a more comprehensive effort to insure a well-run nursing home system.[106]

Nevertheless, the eradication of the majority of nursing home ills will be slow in coming. Only after years of continuing unwillingness to face the nursing home problem has the United States public shown a present desire to wage battle.

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[105] *Id.* § 2801.

[106] *See* note 90 *supra.*