

# University of Michigan Journal of Law Reform

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Volume 9

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1976

## New York's Revised Nursing Home Legislation

Michael G. McGee

*University of Michigan Law School*

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### Recommended Citation

Michael G. McGee, *New York's Revised Nursing Home Legislation*, 9 U. MICH. J. L. REFORM 375 (1976).

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## LEGISLATIVE NOTES:

### NEW YORK'S REVISED NURSING HOME LEGISLATION

Elderly citizens must cope not only with the physical infirmities of the aged, but also with unique difficulties challenging their survival, and with societal aversion to the condition of old age. The retired elderly face inflation and medical care expenses which often overwhelm their fixed incomes.<sup>1</sup> In addition, unemployment, isolation, and limited social and political influence often leave the aged with no alternative dwelling in later years except a residential health care facility.<sup>2</sup> It is within these facilities, the nursing homes,<sup>3</sup> that the elderly confront the last challenge: to maintain both an incentive to live and a decent existence.<sup>4</sup>

The conditions within nursing homes and the quality of care provided vary considerably, yet recent reports of a congressional subcommittee,<sup>5</sup>

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<sup>1</sup> R. NADER STUDY GROUP, REPORT ON NURSING HOMES, OLD AGE: THE LAST SEGREGATION 22 (1971) [hereinafter cited as R. NADER STUDY GROUP]; Note, *Discrimination Against the Elderly: A Prospectus of the Problem*, 7 SUFFOLK U.L. REV. 917, 917-23 (1973).

<sup>2</sup> R. NADER STUDY GROUP, *supra* note 1.

<sup>3</sup> Most national surveys of nursing homes adopt the following operational definition of "nursing home:"

A facility or unit, however named, which is designated, staffed, and equipped for the accommodation of individuals not requiring hospital care but needing nursing care and related medical services prescribed by or performed under the direction of persons licensed to provide such care or services in accordance with the laws of the State in which the facility is located.

Byron, Calfee & Hiam, *A Model Act for the Regulation of Long-Term Health Care Facilities*, 8 HARV. J. LEGIS. 54 (1970).

The New York Public Health Law defines "nursing home" as

a facility providing therein nursing care to the sick, invalid, infirm, disabled or convalescent persons in addition to lodging and board or health-related service, or any combination of the foregoing, and in addition thereto, providing nursing care and health-related service, or either of them, to persons who are not occupants of the facility.

N.Y. PUB. HEALTH LAW § 2801(2) (McKinney 1971).

<sup>4</sup> R. NADER STUDY GROUP, *supra* note 1, at 123-27. See also Note, *supra* note 1, at 917-20.

<sup>5</sup> See generally SUBCOMM. 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. 76 (1974) [hereinafter cited as INTRODUCTORY REPORT]. For a detailed description of the deficiencies existing in many nursing homes see SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, 93D CONG., 2D SESS., 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 (1974) [hereinafter cited as LITANY OF ABUSES].

studies conducted by consumer organizations,<sup>6</sup> and newspaper investigations<sup>7</sup> indicate that substandard conditions represent an ongoing nationwide scandal. This scandal consists of assaults on human dignity within the nursing homes as well as unsanitary living conditions, physical abuse and poor treatment of residents, inadequate medical care, widespread defrauding of government funding programs, improper use of drugs, poor quality food, and numerous serious safety deficiencies.<sup>8</sup> Statutes at the state<sup>9</sup> and federal<sup>10</sup> levels attempting to remedy these problems have met with little success. At times, poorly planned regulations may actually encourage nursing home operators to reduce the quality of care to bare minimum standards rather than provide an incentive to improve quality.<sup>11</sup>

This note undertakes an analysis of the extensive package of nursing home legislation recently enacted in New York.<sup>12</sup> First, specific regulations will be examined in relation to problems they are designed to remedy. Next, the note critically appraises three key, innovative provisions, making recommendations for implementation or revision of each.<sup>13</sup> Finally, the broad changes needed to bring about lasting improvement of nursing care are discussed and a summary of pending legislation is provided.

## I. THE SETTING FOR THE NEW YORK ENACTMENT

The *New York Times*, in a recent series of articles,<sup>14</sup> focused public attention on deficient conditions in many nursing homes and the disreputable practices of the industry. A published report stated that two-

<sup>6</sup> See generally R. NADER STUDY GROUP, *supra* note 1. For a discussion of recent treatises which brought attention to nursing home abuses see Berman, *The Nursing Home Morass: Likelihood of Extrication and Reform*, 17 ARIZ. L. REV. 357, 358-59 (1975).

<sup>7</sup> For a list of *New York Times* articles on nursing homes see N.Y. Times, Jan. 21, 1975, at 26, col. 5 (city ed.). There have been over fifty major newspaper exposes on nursing homes in the last ten years, according to the Subcommittee of Long-Term Care of the Senate Special Committee on Aging. LITANY OF ABUSES, *supra* note 5, at 206.

<sup>8</sup> See generally LITANY OF ABUSES, *supra* note 5, at 169.

<sup>9</sup> See generally Annot., 97 A.L.R.2d 1187 (1964).

<sup>10</sup> R. NADER STUDY GROUP, *supra* note 1, at 50-53.

<sup>11</sup> Reliance on a single level of care in Massachusetts led to "quantitative deficiency for personal care or limited nursing care facilities, and quantitative deficiency in those facilities providing intensive rehabilitation or convalescent care." Address by David R. Kinloch, Director of Medical Care, Department of Public Health of Massachusetts, at Annual Meeting of Nursing Home Administrators, Dec. 9, 1969, in N.Y. Times, Jan. 21, 1975, at 20, col. 5-7.

<sup>12</sup> N.Y. PUB. HEALTH LAW art. 28 (McKinney Supp. 1975-76).

<sup>13</sup> The three provisions which will be discussed in detail are: receivership, N.Y. PUB. HEALTH LAW § 2810 (McKinney Supp. 1975-76) see text accompanying notes 83-105 *infra*; rates of payment, N.Y. PUB. HEALTH LAW § 2808 (McKinney Supp. 1975-76) see text accompanying notes 106-14 *infra*; rights of patients in certain medical facilities, N.Y. PUB. HEALTH LAW § 2803-c(3)(h) (McKinney Supp. 1975-76) see text accompanying notes 115-37 *infra*.

<sup>14</sup> For a series of *New York Times* articles on nursing home deficiencies see N.Y. Times, Oct. 7, 1974, at 1, col. 1; N.Y. Times, Oct. 8, 1974, at 48, col. 1; N.Y. Times, Oct. 9, 1974, at 85, col. 1; N.Y. Times, Oct. 10, 1974, at 42, col. 4; N.Y. Times, Nov. 15, 1974, at 38, col. 1.

thirds of all New York nursing homes had serious deficiencies rendering them unsafe; three-fourths had major structural deficiencies; and 59 percent were unsafe as potential fire traps.<sup>15</sup> The United States Senate Subcommittee on Long-Term Care and the Temporary State Commission on Living Costs, the Stein Commission, disclosed that nursing home operators overstated expenses and made profits exceeding 20 percent on investment while most offered inadequate care to infirm, elderly patients.<sup>16</sup> In response to these disclosures, Governor Carey of New York appointed the Moreland Act Commission to conduct an investigation of New York nursing homes and recommend legislation to increase fiscal and legal accountability and improve standards throughout the industry.<sup>17</sup> That Commission's recommendations are embodied in ten of the thirteen nursing home bills enacted by the legislature in 1975.<sup>18</sup>

The New York legislation will be examined in relation to those nursing home industry abuses which each provision is designed to remedy. The problems revealed in New York nursing homes are by no means unique to that state<sup>19</sup> and study of these provisions and their impact should be undertaken to guide future drafters of similar legislation.

## II. THE PROVISIONS OF THE 1975 NEW YORK PUBLIC HEALTH ACT

### A. State Funding: Rates of Reimbursement

Ideally, state reimbursement of nursing homes for expenditures should be structured to offer incentives to improve conditions by compensating at a higher level those nursing homes which provide higher quality nursing care. Unfortunately, reimbursement at a single, uniform rate has the opposite effect.<sup>20</sup> An overly simplified rate structure which pays a higher rate for the care of nonambulatory patients may actually encourage homes to keep their patients bedridden, thereby providing no economic inducement to offer quality care. Where reimbursement is merely a factor of total expenses, the operator of a nursing home may elect to inflate costs and greatly overspend, often in lobbying, advertising, and entertain-

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<sup>15</sup> LITANY OF ABUSES, *supra* note 5, at 208.

<sup>16</sup> N.Y. Times, March 28, 1975, at 56, col. 1-3. See also The Albany Letter 9, Aug. 25, 1975 (McKinney Supp. No. 9, 1975). The Stein Commission confirmed and highlighted the many abuses within the New York Nursing Home system. N.Y. Times, Jan. 12, 1975, at 41, col. 1. For a discussion of unconscionable profits see N.Y. Times, Jan. 15, 1976, at 1, col. 2.

<sup>17</sup> N.Y. Times, July 11, 1975, at 1, col. 5. See also N.Y. STATE MORELAND ACT COMM'N ON NURSING HOMES AND RESIDENTIAL FACILITIES, FIRST REPORT, REGULATING NURSING HOME CARE: THE PAPER TIGERS (1975).

<sup>18</sup> N.Y. Times, July 11, 1975, at 1, col. 5.

<sup>19</sup> For a discussion of the nationwide crisis see generally LITANY OF ABUSES, *supra* note 5.

<sup>20</sup> Address by David Kinloch, *supra* note 11.

ment.<sup>21</sup> Another method used to overstate operating expenses is to resell the nursing home many times among the owner's family members.<sup>22</sup> A related concern is that any reimbursement plan must be adequate to meet the financial needs of properly administered nursing homes.

The New York legislative response to these problems directs the Commissioner of the New York Department of Health to develop a reimbursement rate formula which will relate payment to the operation and program management of each facility as well as the quality of patient care provided.<sup>23</sup> Additionally, all reimbursement is to be linked to the "prudent buyer" concept to discourage inflation of costs.<sup>24</sup> All costs related to lobbying, political contributions, disallowed advertising, and employee or owner entertainment are specifically excluded from the reimbursement formula.<sup>25</sup>

As an afterthought, the Senate unanimously approved a bill<sup>26</sup> to curtail the practice of selling a home between relatives in an attempt to again claim the purchase price and initial expenses as operating costs.<sup>27</sup> Requested reimbursement for such expenses will be refused if the Department of Health determines the transfers were not bona fide or "at arms length."<sup>28</sup>

The Commissioner of the Health Department must conduct an on-site audit of facility financial records, establish uniform criteria for evaluation of facilities, and rank each home for reimbursement purposes based on those criteria.<sup>29</sup> These ratings, based on at least five categories, are to be conspicuously posted by each facility. Finally, the bill provides that the Department may require a security bond from any facility placed in the lowest category to assure that all future obligations are met.<sup>30</sup>

Individual audits of facilities, as well as increased inspection<sup>31</sup> and more stringent enforcement of these regulations, entails additional administrative expense. The higher rates paid to homes where standards are upgraded will also escalate costs, particularly if numerous patients are transferred to these homes from substandard facilities. Early indications, however, are that these expenses have been offset by savings realized through extensive collection of overpayments and the reduction of rates paid to lower quality facilities as determined by the new cost audits of the legislation.<sup>32</sup>

<sup>21</sup> N.Y. Times, July 12, 1975, at 12, col. 1. The New York Temporary State Commission on Living Costs and the Economy provides illustrations of the methods by which nursing homes overbilled taxpayers at least \$400 million in New York state. N.Y. Times, March 28, 1975, at 48, col. 1.

<sup>22</sup> N.Y. Times, July 10, 1975, at 15, col. 1; N.Y. Times, July 11, 1975, at 1, col. 5.

<sup>23</sup> N.Y. PUB. HEALTH LAW § 2808 (McKinney Supp. 1975-76).

<sup>24</sup> *Id.* § 2808(1)a. The term "prudent buyer" is used in the statute but not defined.

<sup>25</sup> *Id.* § 2808(2).

<sup>26</sup> *Id.* § 2808(1)c (McKinney Supp. 1975-76).

<sup>27</sup> N.Y. Times, July 12, 1975, at 12, col. 1.

<sup>28</sup> N.Y. PUB. HEALTH LAW § 2808(1)b, c.

<sup>29</sup> *Id.*

<sup>30</sup> *Id.* § 2809.

<sup>31</sup> See text accompanying notes 47-49 *infra*.

<sup>32</sup> Commissioner Whalen of the State Health Department stated that several million dollars in overpayments had been collected by the state and overall rate adjustment

*B. Patient's Bill of Rights*<sup>33</sup>

A United States Senate Subcommittee on Long-Term Care report has concluded that many elderly citizens live in fear of being forced into nursing homes,<sup>34</sup> which many view as warehouses for the dying.<sup>35</sup> The assault on human dignity within nursing homes includes mental and physical abuse, often by facility personnel who are unqualified to provide adequate care.<sup>36</sup> Other infringements upon the rights of individual patients include widespread misuse of drugs as "chemical straight-jacket[s]"<sup>37</sup> and reprisals against patients who complain.<sup>38</sup> The subcommittee report recommended stricter state regulations to deter such abuses.<sup>39</sup>

The New York Legislature, aware of these problems, enacted the patient's "bill of rights," which is intended to protect patients from abuse and avoid infringement of civil and religious rights.<sup>40</sup> Individual patient rights protected include the rights to: private communication with the patient's physician or any other person; present grievances to the institution, government officials, or any other person; manage personal financial affairs or receive quarterly accountings of all facility transactions in their behalf; freedom from physical and mental abuse; freedom from physical or chemical restraints, except in emergency; receive adequate medical care; privacy and confidentiality in treatment and caring for personal needs; and security in storing possessions.<sup>41</sup> A copy of these patient rights is to be presented to every resident at or prior to admission.<sup>42</sup>

Any nursing home and every controlling person<sup>43</sup> of a residential health care facility is liable under this law for deprivation of any right or benefit protected by the bill of rights.<sup>44</sup> In addition to compensatory damages the legislation authorizes the award of punitive damages for any willful depriva-

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and reduction of advanced payment has saved millions more. N.Y. Times, Nov. 12, 1975, at 40, col. 1.

<sup>33</sup> N.Y. PUB. HEALTH LAW § 2803-c (McKinney Supp. 1975-76); see text accompanying notes 115-37 *infra*.

<sup>34</sup> LITANY OF ABUSES, *supra* note 5, at 163; *Hearings Before the Subcomm. on Long-Term Care of the Senate Special Comm. on Aging*, 91st Cong., 2d Sess., pt. 10, at 2546 (1970) [hereinafter cited as *Hearings*].

<sup>35</sup> *Hearings*, *supra* note 34, at 2593.

<sup>36</sup> R. NADER STUDY GROUP, *supra* note 1, at 100-01.

<sup>37</sup> LITANY OF ABUSES, *supra* note 5, at 188. For a full discussion of problems connected with the use of drugs in nursing homes see generally SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, 94TH CONG., 2D SESS., NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, SUPPORTING PAPER NO. 2, DRUGS IN NURSING HOMES: MISUSE, HIGH COSTS, AND KICKBACKS (Comm. Print 1975) [hereinafter cited as DRUGS IN NURSING HOMES].

<sup>38</sup> LITANY OF ABUSES, *supra* note 5, at 191.

<sup>39</sup> DRUGS IN NURSING HOMES, *supra* note 37, at 274.

<sup>40</sup> N.Y. PUB. HEALTH LAW § 2803-c (McKinney Supp. 1975-76).

<sup>41</sup> *Id.*

<sup>42</sup> *Id.* § 2803-c(4).

<sup>43</sup> A "controlling person" is "any person who has the ability, directly or indirectly, to direct or cause the direction of the management or policies of said facility." *Id.* § 2808-a(2).

<sup>44</sup> *Id.* § 2801-d.

tion of protected patient rights.<sup>45</sup> Reasonable attorney's fees may also be awarded to any resident securing a judgment against a facility.<sup>46</sup>

### *C. Inspection and Enforcement*

At a 1970 congressional hearing, Representative David Pryor labeled the inspection of nursing homes a "national farce."<sup>47</sup> The absence of uniform inspection procedures and standards, even within a single agency, encourages inspectors to concentrate on the physical structures of nursing homes rather than the quality of the care provided.<sup>48</sup> Ineffective inspection is further insured by previsit warnings by agency employees and the failure of government officials to act upon observed deficiencies.<sup>49</sup>

License revocation is the only penalty some states provide to control substandard nursing homes.<sup>50</sup> Even where revocation is warranted, however, there is often considerable reluctance to resort to this measure because of the difficulty and expense incurred in relocating residents.<sup>51</sup> Extensive delay necessitated by the required revocation proceedings underscores the need for more flexible sanctions.<sup>52</sup> Civil penalties providing numerous enforcement options would allow regulating officials to tailor the fine to each violation and thus more effectively force compliance with statutory standards.<sup>53</sup> The predecessor of the present New York legislation permitted a single fine of up to \$1,000 per violation.<sup>54</sup> Such a one-time assessment might well be treated by some nursing home operators merely as a cost of doing business when repairs or other costs of compliance exceed the fine. Another problem with such fines is the difficulty of enforcing them against those owners who actually dictate facility policies.<sup>55</sup>

The revised New York Act strengthens inspection requirements and provides for greater flexibility and severity in enforcement. The Department of Health must inspect each nursing home at least twice annually.<sup>56</sup> One inspection is to be unannounced and the statute provides for the suspension of any Department employee giving advance warning to the

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<sup>45</sup> *Id.* § 2801-d(2).

<sup>46</sup> *Id.* § 2801-d(6).

<sup>47</sup> 116 CONG. REC. 27036-40 (1970). One commentator decries the inability of public outrage and government investigation to remedy the nursing home scandal. Berman, *supra* note 6, at 357-58.

<sup>48</sup> INTRODUCTORY REPORT, *supra* note 5, at 76.

<sup>49</sup> *Id.*; R. NADER STUDY GROUP, *supra* note 1, at 49-50.

<sup>50</sup> State statutes providing for revocation of facility operating licenses include ALASKA STAT. § 18.20.050 (1962); ILL. ANN. STAT. ch. 111-1/2, § 35.22 (Smith-Hurd 1966).

<sup>51</sup> N.Y. Times, Nov. 12, 1975, at 40, col. 1.

<sup>52</sup> For a discussion of the use of receivership as a flexible sanction and the problems of delay and procedural compliance see text accompanying notes 97-105 *infra*.

<sup>53</sup> Byron, Calfee & Hiam, *supra* note 3, at 63-66. See generally N.Y. Times, June 4, 1975, at 1, col. 7.

<sup>54</sup> N.Y. PUB. HEALTH LAW § 12 (McKinney Supp. 1975-76).

<sup>55</sup> R. NADER STUDY GROUP, *supra* note 1, at 91-99.

<sup>56</sup> N.Y. PUB. HEALTH LAW § 2803(1)(a) (McKinney Supp. 1975-76).

facility.<sup>57</sup> Copies of inspection reports are to be kept by each facility as public records. A summary of the most recent report, including any deficiencies and improvements required, must be posted in prominent locations in every nursing home to allow access to this information by patients and the public.<sup>58</sup>

The Commissioner of the Department of Health is to develop a detailed inspection checklist to assist inspectors in evaluating each facility.<sup>59</sup> After inspection, each facility is to be rated, based on the Commissioner's uniform criteria, and the rating must set forth both the type and degree of severity of deficiencies as well as areas of superior performance. The specificity of the inspection guidelines will probably determine their effectiveness. The Commissioner should avoid promulgating vague or subjective inspection rules and procedures; the lack of specificity makes the rules less instructive to nursing home operators and may also render the rules invalid.<sup>60</sup>

The New York Hospital Review and Planning Council is empowered to adopt regulations establishing a system of penalties setting a maximum fine of \$1,000 per day for each continuing violation of rules and regulations established pursuant to the package of nursing home legislation.<sup>61</sup> A nursing home must be given written notice of the violation and the improvement required thirty days before the penalty may be assessed.<sup>62</sup>

A hearing must be held before a nursing home operating certificate can be revoked or suspended.<sup>63</sup> However, temporary suspension or limitation of the certificate is permitted if, after notice to the facility, the Department of Health finds that continued operation would impose an imminent threat to the health and safety of any patient.<sup>64</sup> Once the operating certificate of a nursing home is revoked, the Commissioner is empowered to appoint a receiver to permit orderly patient transfer or temporary operation when

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<sup>57</sup> *Id.* For a summary of the difficulties inherent in the inspection process as well as the possibility that unannounced inspections may violate the fourth amendment's prohibition against unreasonable search and seizure, see Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304, 324-29 (1975). States which have enacted statutes providing expressly for unannounced inspections and penalties for inspectors giving advance warnings include California and Michigan. CAL. HEALTH & SAFETY CODE § 1421 (West Supp. 1975); MICH. COMP. LAWS ANN. § 331.653(e)(2) (1975).

<sup>58</sup> N.Y. PUB. HEALTH LAW § 2896-h (McKinney Supp. 1975-76).

<sup>59</sup> *Id.* § 2803(1)(c).

<sup>60</sup> One example of the difficulties resulting from vaguely worded regulations is found in a recent court decision holding the Department of Health regulations on nursing home structural requirements invalid as vague and meaningless. — v. — (App. Div. Jan. 22, 1976), in N.Y. Times, Jan. 23, 1976, at 53m, col. 1 (city ed.). See generally INTRODUCTORY REPORT, *supra* note 5, at 76.

<sup>61</sup> N.Y. PUB. HEALTH LAW § 2803(6) (McKinney Supp. 1975-76); N.Y. Times, June 4, 1975, at 1, col. 7.

<sup>62</sup> N.Y. PUB. HEALTH LAW § 2803(7) (McKinney Supp. 1975-76).

<sup>63</sup> *Id.* § 2806(2).

<sup>64</sup> A nursing home operating certificate might be limited, for example, by cutting off all government funding or by not allowing the facility to accept any new patients prior to a determination that conditions meet minimum standards. *Id.*



necessary to protect residents.<sup>65</sup> The receivership provision is an innovative enforcement option which may allow protection of patients without the difficult procedure of revocation and closure.<sup>66</sup>

Finally, the Act makes it unlawful for a person to fraudulently seek payment of public funds for services or supplies under Medicare funding.<sup>67</sup> The state may maintain an action for treble damages when a false statement is made in a claim for payment.<sup>68</sup>

#### D. Accountability of Controlling Persons

The trend in nursing home ownership and operation has been toward control by large corporations<sup>69</sup> and a small number of wealthy individuals.<sup>70</sup> These owners are the policy-makers for nursing homes, but they are often immune from penalties provided by existing laws. Effective enforcement of regulations requires that such individuals and entities be both financially and legally accountable.

The New York legislation requires extensive reporting of financial and administrative data.<sup>71</sup> Each nursing home must file an annual report setting forth its assets, liabilities, revenues, expenses, and additional charges and credits. The names and addresses of all owners and operators must be disclosed.<sup>72</sup> Detailed reporting concerning any payments exceeding \$500 to any individual with an ownership in the facility is also required.<sup>73</sup> All applications for an operating certificate must include the name, certain personal information, and the extent of interest of any individual or organization with 10 percent or greater interest in the land, building, mortgage, or lease of the facility.

Liability for damages and civil penalties extends to all "controlling persons."<sup>74</sup> Any person who has the direct or indirect power to make policy decisions or to direct facility management is liable to the state, individual patients, or a class of patients to the same extent as the nursing home.<sup>75</sup>

<sup>65</sup> *Id.* § 2810(2)(a). See generally Grad, *Upgrading Health Facilities: Medical Receiverships as an Alternative to License Revocation*, 42 COLO. L. REV. 419, 431-36 (1971). For a discussion of the difficulties of moving elderly home residents from a closed facility see *Pennsylvania to Move Aged from Substandard Care Homes*, AGING, No. 233, March 1974, at 13.

<sup>66</sup> N.Y. PUB. HEALTH LAW § 2810 (McKinney Supp. 1975-76); Grad, *supra* note 65, at 432-33.

<sup>67</sup> N.Y. SOC. SERV. LAW § 145-b(1) (McKinney Supp. 1975-76).

<sup>68</sup> *Id.* § 145-b(2).

<sup>69</sup> R. NADER STUDY GROUP, *supra* note 1, at 94-99. See generally Elliot, *Unhealthy Growth: The Nursing Home Business Is Expanding at a Feverish Pace*, BARRONS, Feb. 10, 1969, at 3-16.

<sup>70</sup> N.Y. Times, Oct. 31, 1974, at 45, col. 1; N.Y. Times, Jan. 21, 1975 at 20, col. 4-8; N.Y. Times, July 3, 1975, at 12, col. 4-8. See also R. NADER STUDY GROUP, *supra* note 1, at 92-95.

<sup>71</sup> N.Y. PUB. HEALTH LAW § 2805-e (McKinney Supp. 1975-76).

<sup>72</sup> *Id.*

<sup>73</sup> *Id.* § 2805-e(1)(g).

<sup>74</sup> *Id.* § 2808-a(1). See note 43 *supra*.

<sup>75</sup> N.Y. PUB. HEALTH LAW § 2808-a(2) (McKinney Supp. 1975-76).

### *E. License Standards*<sup>76</sup>

In New York, small groups of individuals have achieved increasing control over large numbers of nursing homes which they proceed to operate below minimum standards.<sup>77</sup> Operators of substandard facilities have continued, because of the failure of state supervision, to receive new operating certificates.<sup>78</sup> In addition, states have failed to require training or experience for the certification of nursing home administrators. As a result, individuals with little skill, experience or financial backing undertake this critical responsibility, often to the detriment of their patients.<sup>79</sup>

The New York nursing home statute, as amended, requires that the competence, character, and standing in the community of all proposed incorporators, directors, sponsors, operators, and administrators be affirmatively evidenced for certificate approval.<sup>80</sup> If investigation into the activities of such individuals for the preceding ten years discloses any affiliation with inferior health care facilities, the certificate may not be approved.<sup>81</sup> The Department of Health must be satisfied with the financial resources and sources of future revenue before approval may be granted to the proposed facility.<sup>82</sup>

## III. ANALYSIS OF KEY PROVISIONS

### *A. Receivership*<sup>83</sup>

The New York nursing home legislation includes an innovative provision which allows appointment of a receiver under certain circumstances.<sup>84</sup> Receivership is designed to facilitate the forced improvement of nursing home standards, or the transfer of residents, without terminating

<sup>76</sup> See generally R. NADER STUDY GROUP, *supra* note 1, at 81-91.

<sup>77</sup> N.Y. Times, Jan. 15, 1975, at 17, col. 1-2; N.Y. Times, Jan. 1, 1975, at 15, col. 1-4.

<sup>78</sup> For a description of the alleged corruption which prevented enforcement of nursing home laws against influential nursing home operators see N.Y. Times, Feb. 26, 1975, at 21, col. 2.

<sup>79</sup> R. NADER STUDY GROUP, *supra* note 1, at 82.

<sup>80</sup> N.Y. PUB. HEALTH LAW § 2801-a(3)(b) (McKinney Supp. 1975-76). See N.Y. Times, June 4, 1975, at 22, col. 2, for an example of the changed requirements to receive an operating certificate.

<sup>81</sup> N.Y. PUB. HEALTH LAW § 2801-a(3)(b).

<sup>82</sup> *Id.* § 2801-a(3)(c).

<sup>83</sup> See note 65 and accompanying text *supra*.

The traditional purpose of receivership is to maintain property interests and to prevent valuable assets from being lost. In the hospital and health facility situation, the problem is a different one, because a hospital which is being soundly run from the economic point of view may well be wholly inadequate from the point of view of patient welfare. Hence, the remedy here proposed would provide for a temporary takeover of the institution, not for the sake of preserving its financial or economic status, but rather for the sake of putting it into the kind of condition that would best serve the interests of the patients.

Grad, *supra* note 65, at 432.

<sup>84</sup> N.Y. PUB. HEALTH LAW § 2810(1) (McKinney Supp. 1975-76).

essential services.<sup>85</sup> By stripping control from owners, receivership provides an opportunity for immediate correction of dangerous conditions within a nursing home.

The purposes served by appointment of a receiver include: protection of patients from threatening conditions; provision for an alternative to facility closure; prevention of the emotional and social suffering to patients which occurs with dislocation; and saving of the expenses required to relocate residents.<sup>86</sup> The receiver may seek to operate and upgrade a substandard facility or may merely allow gradual transfer of patients to homes which comply with standards.

The owners of a nursing home may request that the Department of Health appoint a receiver to take over operation of that facility.<sup>87</sup> Alternatively, upon revocation of a facility's operating certificate, the Commissioner may petition the supreme court in the county where the facility is located to appoint a receiver to undertake administration of the facility.<sup>88</sup> Procedural safeguards are provided to protect the property rights of nursing home owners. Revocation of the operating certificate and expiration of all appeals are prerequisites of the appointment of a receiver. The court, after the required service of process, conducts an evidentiary hearing which takes precedence over all matters on the court calendar.<sup>89</sup>

The appointment of a receiver entitles facility owners to a court-determined fair monthly rental for the nursing home. The receiver has extensive powers to operate the facility, eliminate deficiencies which threaten patients, provide necessary health care, and provide for orderly transfer of patients.<sup>90</sup> He may make contracts, collect debts, and incur expenses for repairs, improvements, or supplies. Expenditures for major alterations of the facility physical plant are limited.<sup>91</sup> The receiver is to compensate owners for inventory supplies to avoid confiscation of property.<sup>92</sup>

All civil and criminal liability of owners imposed prior to receivership remains unchanged by receivership proceedings. Tax liability and oper-

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<sup>85</sup> Grad, *supra* note 65, at 431. Since 1968 there has been a New York legislative provision authorizing appointment of a receiver for nonprofit nursing home companies. It allows receivership "to correct actions prejudicial" to the interests of residents and the public. N.Y. PUB. HEALTH LAW § 2862(4) (McKinney 1971).

<sup>86</sup> See generally Grad, *supra* note 65.

<sup>87</sup> N.Y. PUB. HEALTH LAW § 2810(2)(b) (McKinney Supp. 1975-76).

<sup>88</sup> *Id.* § 2810(2)(a).

<sup>89</sup> *Id.* § 2810(2)(b).

<sup>90</sup> *Id.* § 2810(2)(c).

Any receiver appointed pursuant to this subdivision shall have all of the powers and duties of a receiver appointed in an action to foreclose a mortgage on real property, together with such additional powers and duties as are herein granted and imposed.

*Id.*

<sup>91</sup> *Id.*

<sup>92</sup> The statute provides that "[n]either the receiver [n]or the department shall engage in any activity that constitutes a confiscation of property without payment of fair compensation." *Id.*

ating and maintenance expenses remain the sole obligations of the owner. Restoration of ownership control must be by order of court, or by terms of an agreement if appointment was requested by the owners.<sup>93</sup> The legislation allows court-ordered termination of a receivership only under the following circumstances:

- (a) eighteen months after the date on which it was ordered; [or]
- (b) when the department grants the facility a new operating certificate . . . ; or
- (c) at such time as all of the patients in the facility have been provided alternative modes of health care, either in another facility or otherwise.<sup>94</sup>

New York's receivership provision is designed to prevent hardship to residents resulting from facility closure. However, no provision is made for a summary hearing and the prompt appointment of a receiver when necessary to protect residents from existing dangerous deficiencies. As a result, the delay necessitated by certificate revocation and appeal expiration renders receivership ineffective for prompt protection of residents. While the statute provides for temporary revocation, suspension, or limitation of an operating certificate where public health and safety are endangered,<sup>95</sup> receivership requires revocation of the nursing home operating certificate prior to the appointment of a receiver.<sup>96</sup> In situations where inspection discloses a serious threat to health and safety there should be legislation permitting immediate appointment of a receiver at the supreme court hearing. This revision would allow appointment before all appeals are exhausted.

Once the receiver is appointed to correct imminently dangerous conditions the nursing home owner would be provided with prompt review or appeal. Such a provision would allow receivership to function as a protective remedy rather than as a mere custodial measure to facilitate orderly closure.

The appointment of a receiver has been upheld as a constitutional exercise of the police power<sup>97</sup> and, in the nursing home context, it may be required for the preservation of health and safety. A court of equity

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<sup>93</sup> *Id.* § 2810(1).

<sup>94</sup> *Id.* § 2810(2)(e).

<sup>95</sup> *Id.* § 2806-a(2).

A certificate may be temporarily suspended or limited without a hearing for a period not in excess of thirty days . . . following a finding by the department that the public health or safety is in imminent danger.

*Id.*

<sup>96</sup> *Id.* § 2810(2)(a).

<sup>97</sup> See *Department of Bldgs. v. Soltzer*, 16 N.Y.2d 915, 212 N.E.2d 154, 264 N.Y.S.2d 701 (1965). For an example of a receivership statute which empowers an enforcement agency to seek appointment of a receiver to take control of dilapidated buildings see N.Y. REAL PROP. ACTIONS LAW §§ 769-782 (McKinney Supp. 1975-76). The constitutionality of the New York receivership provision was upheld in *In re Department of Bldgs.*, 14 N.Y.2d 291, 200 N.E.2d 432, 251 N.Y.S.2d 441 (1964). See generally Note, *Receivership of Problem Buildings in New York City and Its Potential for Decent Housing of the Poor*, 9 COLUM. J.L. & SOC. PROB. 309 (1973).

may exercise the receivership remedy after notice to all interested parties and a hearing.<sup>98</sup> One commentator has maintained that state and federal legislation could provide for the administrative appointment of receivers in urgent situations, either as an alternative to or in addition to equity proceedings.<sup>99</sup> Such legislation would provide that

the function normally served by a court in appointing receivers could be legislatively assigned to the licensing agency . . . . Indeed, in a situation which presented a hazard to health and safety, the law might authorize the agency to act in a summary fashion and with minimal or no prior notice.<sup>100</sup>

The due process issues raised by such a revision require careful examination.<sup>101</sup> While provisions enabling receivers to deal with urgent situations should be adopted, proper safeguards of the property rights of nursing home owners also must be maintained. Nursing home owners will likely argue that appointment of a receiver deprives them, at least temporarily, of property. Similar prejudgment seizures of property have been the subject of recent United States Supreme Court decisions. In *Fuentes v. Shevin*,<sup>102</sup> the Court held invalid two state replevin statutes which failed to provide a hearing prior to state-authorized seizure of property. Subsequently, in *Mitchell v. W. T. Grant Co.*,<sup>103</sup> the Court held that a hearing prior to seizure is not essential if there is prior judicial supervision and an immediate post-seizure hearing is provided. *Fuentes* recognized, however, that "extraordinary situations" may justify postponement of notice and hearing requirements in order to protect important

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<sup>98</sup> See, e.g., *Tennessee Publishing Co. v. Carpenter*, 100 F.2d 728 (6th Cir. 1938), cert. denied, 306 U.S. 659 (1939); *Cortland Lounge, Inc. v. Cohen*, 82 N.Y.S.2d 244 (Sup. Ct. Spec. T. 1948). See generally Regan, *Quality Assurance Systems in Nursing Homes*, 53 J. URBAN L. 153, 194-96 (1975).

<sup>99</sup> Grad, *supra* note 65, at 432-33.

<sup>100</sup> *Id.* at 433. In support of his proposal for streamlined receivership provisions Grad states:

The receivership remedy has been upheld as a constitutional exercise of the police power in all of its other uses. There should be no constitutional objections to such a remedy when applied in the classical context of preservation of health and safety. The imposition of a receivership remedy in summary fashion and without prior notice would be upheld on constitutional grounds similar to those justifying other exercises of police power in instances where the health and safety of the people were endangered.

*Id.* (footnote omitted).

<sup>101</sup> For a discussion of the due process difficulties of receivership when appointed without extensive procedural safeguards see Grad, *supra* note 65, at 431-33. See also text accompanying notes 97-100 *infra*.

<sup>102</sup> 407 U.S. 67 (1972). These replevin statutes failed to provide judicial supervision of the private seizure of property. The Court held that although the seizure was temporary it was within the purview of the due process clause. 407 U.S. at 84-90.

<sup>103</sup> 416 U.S. 600 (1974). This case may be distinguished from *North Georgia Finishing, Inc. v. Di-Chem, Inc.*, 419 U.S. 601 (1975), in which the Court invalidated Georgia's prejudgment garnishment statute. That statute failed to provide a hearing after seizure and required no participation or supervision by a judicial officer. 419 U.S. at 607.

government and public interests.<sup>104</sup> The public has a significant interest in the protection of nursing home residents by prompt appointment of a receiver. As proposed, the procedure for such appointment should be revised to allow a judge to act only following his review of the specific allegations of the Department of Health. The statute should also provide a hearing after appointment at which nursing home owners could contest the Department's allegations.<sup>105</sup> Such a provision would satisfy due process objections and would give new vitality to receivership as a means of expeditiously protecting nursing home patients from conditions endangering health and safety.

### B. Rates of Reimbursement<sup>106</sup>

The Commissioner of the Department of Health has been vested with considerable responsibility for the development and implementation of regulations governing nursing home reimbursement rates.<sup>107</sup> The provision which requires that the quality of patient care be related to the rate of payment directs the Commissioner to establish interim regulations and to make such ongoing recommendations for revisions as are necessary.<sup>108</sup> The regulations must relate the rate of payment to each facility's "operation and program management . . . as well as to the quality of patient care provided by the facility."<sup>109</sup> This legislation recognizes the importance of basing regulations not on the needs of patients within a home, but on the quality of care provided for those patients. Reimbursement rates may serve as an incentive to nursing homes to upgrade care. It is also possible, however, that such a structure may indirectly discourage the rehabilitation of patients or exclude certain classes of patients from nursing care. For example, an escalated rate of payment for nonambulatory patients may encourage nursing homes to drug patients or otherwise prevent activity and thereby profit from bedridden patients. On the other hand, use of a single flat rate of payment, such as one based on facility expenses,<sup>110</sup> will result in overexpenditure by operators.<sup>111</sup> Finally, basing the reimbursement solely on the number of patients in a facility without regard to the care provided will result in competition for those residents requiring the least assistance. Such patients are less costly to maintain than those who need more nursing care and medical attention. A higher

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<sup>104</sup> 407 U.S. at 90-92. The Court listed several examples of public harm which permit attachment without prior hearing: a bank failure; wartime emergencies; to collect taxes; and to protect the public against misbranded drugs and contaminated food. *Id.* An urgent need for protection of nursing home residents is analogous to the latter public health emergencies.

<sup>105</sup> See notes 95-96 and accompanying text *supra*.

<sup>106</sup> See part II *A supra*.

<sup>107</sup> N.Y. PUB. HEALTH LAW § 2808 (McKinney Supp. 1975-76).

<sup>108</sup> *Id.* § 2808(1)(a). Compare ILL. ANN. STAT. ch. 111-1/2, § 35.26 (Smith-Hurd Supp. 1975-76) which authorizes the Department of Public Health to classify facilities by degree of care provided.

<sup>109</sup> N.Y. PUB. HEALTH LAW § 2808(1)(a) (McKinney Supp. 1975-76).

<sup>110</sup> *Id.* § 2807(3).

<sup>111</sup> See notes 20-22 and accompanying text *supra*.

profit would be made in caring for the less needy resident if the state reimburses on the basis of a patient head count. Reliance on a head count would also encourage nursing homes to overcrowd facilities and provide the minimum level of health care regardless of patient need.

Promulgating broad, vague standards pertaining to levels of care may foster uncertainty and potential legal difficulties.<sup>112</sup> The Commissioner should adopt regulations which indicate the specific elements necessary to achieve a stated level of care. By compliance at a chosen level, a nursing home operator could then elect the facility's rate of reimbursement.

For illustrative purposes, this note will provide an example of four levels of care and the elements that must be maintained by a nursing home in order to be compensated at the corresponding rate. These examples indicate a degree of specificity that is essential to implement the legislative purpose. At each level, necessary medical treatment must be available and a program of activities designed to aid and stimulate elderly patients should be required.<sup>113</sup>

#### Model Levels of Care<sup>114</sup>

##### 1. Intensive Nursing Care:

This level would require a full time medical director and licensed nursing care available at all times. Extensive restorative therapy equipment and the necessary operating personnel are to be maintained and utilized. Equipment to provide emergency treatment should be available.

##### 2. Skilled Nursing Care:

Would provide for a medical director and twenty-four hour licensed nursing care. Access to medical, dental, and psychiatric care, as well as therapy is to be provided to meet patients' continuing needs.

##### 3. Supportive Nursing Care:

Would provide trained nursing personnel at a lower nurse-to-patient ratio than those required in the preceding levels. A program of therapy and activity to assist the elderly in the desire to re-enter the community should also be provided.

##### 4. Residential Care:

Would provide minimum requirements for diets, personnel training, and such basic living conditions as the Commissioner specifies.

Regulations such as those proposed must also guarantee adequate reimbursement to nursing homes and offer incentives for the improvement of the quality of care offered. After the regulations are established, the various elements must be reviewed to guarantee that economic factors do not cause a decline in care offered at homes unable to attain the

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<sup>112</sup> N.Y. Times, Jan. 23, 1976, at 53m, col. 1 (city ed.).

<sup>113</sup> R. NADER STUDY GROUP, *supra* note 1, at 122-23, discusses the importance of activity programs. See also Statement of Dr. Frederick C. Swartz, Chairman of the American Medical Association Commission on Aging, in *Hearings, supra* note 34, at 2643.

<sup>114</sup> The four model levels listed are based upon those suggested by Byron, Calfee & Hiam, *supra* note 3, at 87-89. The elements making up each level have been formulated by the author of this note.

requirements of the next level of care. Each level must be funded to sufficiently compensate nursing homes to prevent the isolation of a class of patients without nursing homes which provide the level of care they need. Finally, nursing home inspection procedures and record-keeping practices must be structured to allow investigators to monitor continued compliance with the established category of care.

### C. *The Chemical Straightjacket*<sup>115</sup>

The widespread practice of excessive sedation of nursing home patients has been referred to by a Senate subcommittee as the "chemical straight-jacket."<sup>116</sup> Through frequent sedation an ambulatory patient may suffer atrophy of essential muscle tone and become bedridden.<sup>117</sup> Perhaps more devastating than the physical damage engendered by excessive drugging is the mental lassitude and isolation it causes. In emergencies, such as smoke from even small fires, a sedated patient will remain helplessly immobile.

Nationwide, Medicare spends an average of \$60 per year on tranquilizers for each nursing home patient.<sup>118</sup> This figure lends credence to reports which state that nursing homes, either by policy or by employee initiative, allow widespread sedation of residents.<sup>119</sup> The reasons advanced to explain excessive sedation are many: overactive or troublesome patients are easily suppressed with drugs; inactive patients are less costly since less care is needed; patients are less likely to complain; mental problems of elderly residents may often be suppressed without expensive care.<sup>120</sup> Additional economic advantages, such as higher state reimbursement<sup>121</sup> or drug company kickbacks, are available.<sup>122</sup> All of these motivations for the use of sedatives result in damage to nursing home patients. The problem is intensified when drugs are distributed by untrained, unlicensed personnel.<sup>123</sup>

The patient's bill of rights contained in the New York legislation seeks to curb such physical and mental abuses.<sup>124</sup> Specifically, the bill provides protection from

<sup>115</sup> DRUGS IN NURSING HOMES, *supra* note 37, at 268.

<sup>116</sup> *Id.*

<sup>117</sup> *Id.* at 281; see NADER TASK FORCE ON NURSING HOMES, NURSING HOMES FOR THE AGED: THE AGONY OF ONE MILLION AMERICANS 191-97 (1970). See also R. NADER STUDY GROUP, *supra* note 1, at xv.

<sup>118</sup> DRUGS IN NURSING HOMES, *supra* note 37, at 269.

<sup>119</sup> *Id.* at 271-72.

<sup>120</sup> *Id.* at 268-70.

<sup>121</sup> See part II *A supra*.

<sup>122</sup> For a full discussion of the problems related to drug kickbacks paid to nursing home operators see generally DRUGS IN NURSING HOMES, *supra* note 37.

<sup>123</sup> Such unsupervised distribution of drugs is one factor causing the high incidence of adverse drug reactions in nursing homes. *Id.* at 259-60. Employees find tranquilizing patients a convenient means of easing their own workload since drugged patients may be ignored and will be incapable of overactive or aggressive behavior. *Id.* at 269-72.

<sup>124</sup> N.Y. PUB. HEALTH LAW § 2803-c(3)(h) (McKinney Supp. 1975-76).



physical and chemical restraints, except those restraints authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency in which case the restraint may only be applied by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of restraint and in the case of use of a chemical restraint a physician shall be consulted within twenty-four hours.<sup>125</sup>

Control of chemical restraints<sup>126</sup> under this provision depends largely on the ability of physicians and nurses in nursing homes to influence nursing home procedures and policy, and also to keep detailed records of every use of chemical restraints. The solution which the legislation provides to remedy oversedation is the requirement of physician approval.<sup>127</sup>

The legislature may ultimately find physician overview to be ineffective. The Senate subcommittee investigating this problem indicated that physicians have, in the past, failed to provide effective review of nursing home practices.<sup>128</sup> Physicians practicing in nursing homes have often abdicated personal responsibility for care of resident patients. Practices such as "lightning rounds" allow a doctor to bill for numerous patient visits while a mere passing glance is all the examination really includes.<sup>129</sup>

The mere requirement of a doctor's signature on reports and prescriptions will not assure meaningful medical review. Rubber stamping of medical records in nursing homes with the doctor's signature is not uncommon.<sup>130</sup> Physicians dealing with home administrators have been known to sign death certificates in blank to allow a saving of time and expense for facility operators.<sup>131</sup>

Any solution to the problem of improper chemical restraint will require that detailed individual medical charts showing drug use be maintained. Comparable records are kept by hospitals, and any additional expense resulting from their use is small when balanced against the importance of such records in attempts to curb drug abuse. Penalties must be exacted for failure to keep individual patient records. A fine should be imposed on any facility and on those employees failing to record drugging or improperly administering sedatives. All inspections of nursing homes should include examination of a random sample of patient medical charts. The availability of such records will facilitate several further approaches to solution of the problem.

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<sup>125</sup> *Id.*

<sup>126</sup> For definition of chemical restraints see LITANY OF ABUSES, *supra* note 5, at 188.

<sup>127</sup> N.Y. PUB. HEALTH LAW § 2803-c(3)(h) (McKinney Supp. 1975-76).

<sup>128</sup> See generally SUBCOMM. 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, THE SHUNNED RESPONSIBILITY 325 (Comm. Print 1975) [hereinafter cited as DOCTORS IN NURSING HOMES]; R. NADER STUDY GROUP, *supra* note 1, at 107-09.

<sup>129</sup> R. NADER STUDY GROUP, *supra* note 1, at 107-09.

<sup>130</sup> *Id.* at 113.

<sup>131</sup> *Hearings Before the Subcomm. on Long-Term Care of the Senate Special Comm. on Aging*, 91st Cong., 2d Sess., pt. 10, at 802 (1970).

One commentator has recommended that independent medical review groups be utilized to provide ongoing review of the practices of physicians in nursing homes.<sup>132</sup> Implementation of such an impartial review system to scrutinize the actions and records of doctors administering drugs in nursing homes should be considered.<sup>133</sup>

Patients should be notified of their rights concerning freedom from sedation. The rights to be free of unauthorized sedation, to complain about violations, and to litigate drugging abuses must be communicated to patients if the remedies and actions established by the bill are to have any effect. These specific patient rights should be included in the statement to be provided to every resident under the bill of rights provision.<sup>134</sup>

All sedation should, as the bill provides, be approved by a physician. This approval should be in writing and dated by the physician and then sent to an appropriate official. The legislature might designate a nursing home advocate,<sup>135</sup> a medical review organization, or the Commissioner of the Department of Health to receive a copy of the sedation report. The report should include the type of sedation, facility and physician names, patient's name, and the reason for sedation. No single report of sedation would be cause for review but such a system would allow the official to recognize any pattern of abuse.

The concept of a nursing home advocate has particular advantage as a method to oversee nursing home compliance with regulations against drug abuse. The advocate concept would, if instituted, provide a consumer protection official who could act on patient complaints, provide independent nursing home review, and also increase public awareness and involvement with the institutionalized elderly. There is legislation pending in New York which would provide a nursing home advocate in every county.<sup>136</sup> The advocate would perform the above-mentioned functions and act as a patient representative. Effective representation by nursing home advocates would require that they be empowered to have access to patients and records and also to bring civil actions on behalf of those patients unable to assert their own legal rights.

As part of a long term solution to the drug abuse problem, the Senate subcommittee has recommended increased training in drug administration

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<sup>132</sup> Welch, *Professional Standards Review Organizations—Problems and Prospects*, 289 *NEW ENGLAND J. OF MED.* 291 (1973).

<sup>133</sup> R. NADER STUDY GROUP, *supra* note 1, at 77. See generally Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 *GEO. WASH. L. REV.* 822 (1974).

<sup>134</sup> N.Y. PUB. HEALTH LAW § 2803-c(4) (McKinney Supp. 1975-76).

<sup>135</sup> N.Y. Times, July 13, 1975, at 1, col. 1. Five experimental ombudsman programs were funded in June 1972, four with state governments, and the fifth sponsored by the National Council of Senior Citizens. *INTRODUCTORY REPORT*, *supra* note 5, at 100-02.

<sup>136</sup> S. 4541, N.Y. Senate 198th Sess. (1975); S. 269 was passed in 1975 but vetoed. Another advocate bill passed in the Senate but was voted down without discussion by the Assembly on the final day of the session. N.Y. Times, July 13, 1975, at 1, col. 1.

by nursing and medical schools.<sup>137</sup> Additionally, a medical specialty in geriatrics or in institutional care for the elderly should be encouraged.

#### IV. CURRENT DEVELOPMENTS AND PROPOSED LEGISLATION

The New York nursing home legislation package is an innovative attempt to remedy the problems which have for many years combined to make nursing homes dangerous and depressing. The early response to the legislation has revitalized public concern, aided enforcement of nursing home standards, and strengthened pressure against substandard homes. In 1975 the New York Health Department closed sixty-three nursing homes<sup>138</sup> and, according to the Temporary State Commission on Living Costs and the Economy,<sup>139</sup> there has been, after years of paralysis, a radical change in the enforcement climate throughout New York.

Additional nursing home legislation is currently under consideration in New York. Of particular importance are proposed bills to establish a system of independent nursing home advocates or ombudsmen in every county.<sup>140</sup> As indicated in connection with the issue of illegal restraints,<sup>141</sup> such patient advocates are thought to provide a valuable tool by which the rights of nursing care consumers may be protected.

Additional proposed legislation would prohibit the issuance of an operating certificate for any proprietary nursing home.<sup>142</sup> This bill responds to the sentiment of observers that the profit motive has proved itself incompatible with adequate care of the elderly.<sup>143</sup> In contrast, Morris Abram, Chairman of the Moreland Commission, has concluded that proprietary homes are still an essential aspect of the long-term care system.<sup>144</sup> Another bill seeks to authorize the maintenance of cooperative residences for the elderly who might otherwise be forced to enter nursing homes.<sup>145</sup> One apparently ill-fated provision sought to prohibit elected state officials from representing, operating, or investing in nursing homes.<sup>146</sup>

#### V. CONCLUSION

This note has reviewed the 1975 New York nursing home legislation, made recommendations for additional provisions in certain key areas,

<sup>137</sup> DOCTORS IN NURSING HOMES, *supra* note 128.

<sup>138</sup> N.Y. Times, Jan. 23, 1976, at 53m, col. 1 (city ed.).

<sup>139</sup> N.Y. Times, Nov. 12, 1975, at 40, col. 1.

<sup>140</sup> See notes 136-37 and accompanying text *supra*.

<sup>141</sup> *Id.*

<sup>142</sup> N.Y. Times, Nov. 12, 1975, at 40, col. 1. See also A. 7382, N.Y. Assembly 198th Sess. (1975); Regan, *supra* note 98, at 210-14.

<sup>143</sup> R. NADER STUDY GROUP, *supra* note 1, at 19; N.Y. Times, Jan. 15, 1976, at 1, col. 2.

<sup>144</sup> N.Y. Times, Nov. 12, 1975, at 40, col. 1.

<sup>145</sup> N.Y. Times, Jan. 15, 1975, at 58, col. 5 (city ed.).

<sup>146</sup> The Moreland Commission Report discusses the failure of the New York Legislature to pass a bill prohibiting state officials from maintaining an interest in nursing homes. N.Y. Times, Feb. 26, 1976, at 1, col. 1.

and summarized a few of the related bills now pending. The recommendations suggested revisions of the New York legislation which would strengthen key provisions. Receivership could be a more effective protective remedy if the statute were amended to avoid unnecessary procedural delay. A model rating scheme has been included to indicate the form and the specificity essential to such regulations. Finally, legislation should be enacted to establish independent patient advocates to provide representation and a voice for nursing home residents. Hopefully, the New York experience and that state's development of an effective nursing home statute will provide a model for other states facing similar problems. Within New York, continued enforcement and revision of regulations by the legislature, the Commissioner of the Health Department, and patient advocates, are essential if conditions in nursing homes are to continue to improve.

Health care professionals must assert new influence, and public awareness of the problems must be maintained, if nursing home conditions are to improve and such institutions are to lose their reputation among the elderly as warehouses for the dying. Although a final solution to the problems faced by the elderly in nursing homes may require a change in basic attitudes about the aged, legislative reform and diligent enforcement offer a solution to a national crisis and hope for the elderly.

—*Michael G. McGee*