

[I.] **Know the primary sources of law concerning nursing homes**

[I.] [A.] State licensure law: MCLA §§ 333.20101 et seq.; AC,R 325.20101 et seq.

[I.] [A.] Federal certification law: 42 U.S.C. §§ 1395i-3, 1396r et seq.; 42 C.F.R. Part 483

[I.] [A.] See also HCFA State Operations Manual and Skilled Nursing Facility Manual (available on the web at www.hcfa.gov) and state policy directives (available from the Michigan Department of Consumer and Industry Services (MDCIS)).

[I.] [A.] Consider other applicable laws such as the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq.; 29 U.S.C. § 794; consumer protection laws, etc. These laws can offer considerable protection to residents and permit creative legal strategies, but are seriously underutilized.

NB: Michigan's nursing home law has not been amended to comply in all respects with the federal Nursing Home Reform Law. Therefore, in instances in which the laws conflict and federal law offers stronger protection to residents (e.g., 30 days' advance notice generally required before an involuntary discharge), federal law prevails. However, in instances in which state law is stronger than federal law, advocates should assert state law protections to benefit residents.

[I.] **Nursing home placement should be made only after careful consideration**

A. Nursing homes are only one part of the long term care continuum. Consumers should consider all less restrictive (and likely less expensive) options prior to nursing home placement including adult foster care or homes for the aged, assisted living, in home services, home and community based waiver services, adult day care, etc.

B. Sources of information on long term care options include the local Area Agency on Aging and private care managers. Clients with mental retardation or mental illness who are not already in touch with their local Community Mental Health organization should contact them for information and possible services. Help might also be available to clients who wish to remain in the community from the local Center for Independent Living and from Michigan Protection and Advocacy Service, as well as the Home and Community Based Waiver Program, and other agencies.

NB: Adequate medical and psychological evaluation can be crucial in assisting clients in maintaining maximum independence. There are numerous reversible causes of dementia including drug interactions, urinary tract infections, malnutrition, electrolyte imbalances, etc. Families, professional guardians, and even medical professionals often overlook these explanations for an elder's seeming cognitive decline. Advocates should be familiar with local resources for medical and psychological evaluations and should, whenever possible, encourage thorough evaluation prior to determining that placement is required.

[I.] **Selecting a home**

[I.] [A.] Admission to a nursing home may be traumatic and overwhelming at the best of times and often occurs at a time of crisis. Residents and their families often have very little choice as to which facility they enter since placement generally needs to be done quickly and may be determined by the availability of beds in facilities that accept the resident's method of payment and the proximity of the facility to family members. Hospital discharge planners are often under extreme pressure to place residents and cannot perform an extensive evaluation to ensure the resident is a good match with the facility. Moreover, discharge planners may have little information about the quality and services available at various facilities.

[I.] [A.] Because quality and services differ markedly in different facilities, applicants who have an opportunity to do comparison shopping should visit potential facilities and be diligent in their efforts. Consumers should visit a facility more than once, include visits at night or on weekends since facilities can be very different places outside of the usual work week, and talk to lots of residents and their visitors as well as to the facility staff. Although it is hard for a layperson to evaluate the true quality of care and life in a facility, there are a number of relevant inquiries and observations those visiting should make:

[I.] [A.] [1.] Appearance and Odor – The first consideration should be what the facility looks like and smells like. Although shiny floors and new lobby furniture tell one nothing about the quality of care, prospective residents should ensure that the facility (particularly resident areas such as resident rooms, dining areas, lounges, and bathrooms) does not look dilapidated and neglected. In addition, applicants should consider if the home has an entirely institutional feel or if residents are encouraged to personalize their rooms and if common areas have a somewhat homey or cosy look and feel. A strong odor of urine is a significant warning that incontinent residents may not be cared for adequately and that the facility may not be sufficiently clean. A strong odor of disinfectant can also create an unpleasant environment and may simply cover other less appealing odors. While these indicators might not be present on the official tour of the facility, those considering admission should seek to evaluate all areas in which the applicant might live.

[I.] [A.] [1.] Activities – Since residents generally spend all day, every day in the facility, applicants should evaluate the appropriateness of the offered activities and the willingness of the staff to tailor activities to residents' needs (as required by law; *see* § III B 7 and § IV F of this outline for further discussion). The fact that an activity appears on a calendar or schedule does not mean it is actually offered; applicants should try to observe activities in progress and talk to residents and their families about the quality and quantity of these programs. Are there appropriate activities for alert residents and those with cognitive impairments? Are there opportunities to leave the facility such as shopping trips or trips to local activities? Are there religious services that the resident would appreciate? Are there opportunities to engage in stimulating activities every day?

[I.] [A.] [1.] Resident mix – However good a facility is, it might not be the right

place for the applicant if the population of residents is not appropriate. If a resident is alert, it is important to have other residents with whom he or she can interact. Younger resident might feel isolated in a home that caters almost exclusively to the elderly. Applicants with strong religious or ethnic identities might feel isolated without residents who share those qualities. Applicants should inquire not only what the general mix of the population is but also if cognitively impaired or younger residents are segregated in the facility.

[I.] [A.] [1.] Meals – Meals often become one of the most important parts of a resident’s day. Applicants should review menus (although there may be significant differences between posted menus and meals served), observe mealtimes, and talk to residents and families about the quality and variety of the meals, the availability of substitutions, the degree of help residents who need assistance eating receive from qualified staff, the appropriateness of mealtimes and the availability of snacks.

[I.] [A.] [1.] Restraints – Facilities that are chronically understaffed or lack significant commitment to providing dignified, high quality care may unduly (and illegally) restrain residents for discipline or convenience. Physical restraints include vest restraints; hand ties or mitts; lap trays, seatbelts and lap cushions to prevent residents getting up; gerichairs; and bedrails (See Surveyor’s Guideline to 42 C.F.R. § 483.13(a), Appendix PP to HCFA State Operations Manual). Chemical restraints include psychotropic drugs used to manage residents’ behaviors but not used for the purpose of treating a resident’s medical symptoms. See Surveyor’s Guideline to 42 C.F.R. § 483.13(a), Appendix PP to State Operations Manual. Applicants should ask about the percentage of residents in the facility who are restrained and can compare this information to that reported by similar facilities on HCFA’s “Nursing Home Compare” page. See § III B 2 for more information on the Nursing Home Compare website.

[I.] [A.] [1.] Grievances and concerns – Does the facility have a clearly defined process for residents and their families and advocates to share concerns and have them addressed? Is there an active and independent resident and family council? Applicants should inquire of other residents and their families if these systems work well or if residents and families feel unsatisfied or intimidated by the process.

[I.] [A.] [1.] Willingness to meet individual needs and preferences – the key to a resident’s quality of life may often be the facility’s willingness to adapt, as much as possible, institutional services to the resident’s individual needs and preferences. Residents who have always stayed up late should inquire whether all residents are put to bed at a certain time. Residents who prefer showers to baths or hate waking up early or cannot get going in the morning until their medications kick in and they have a strong cup of coffee should ask whether they can maintain these long time habits in the facility. While these issues might seem trivial, they may be crucial aspects of the resident’s adjustment to life in the facility, in assuring the resident’s quality of life, and in meeting the federal requirement that residents have the right to “[c]hoose activities, schedules,

and health care consistent with [their] interests, assessments, and plans of care” and “[m]ake choices about aspects of [their] li[ves] in the facility that are significant to [them] ” 42 C.F.R. § 483.15(b).

[I.] [A.] There are also a number of resources to which prospective applicants and their families or advocates can refer:

[I.] [A.] [1.] Surveys – Facilities are required to provide access to the most recent survey (HCFA Form 2567) conducted by state and federal surveyors and to any plan of correction in effect. *See* 42 C.F.R. § 483.10(g)(1) and Accompanying Surveyor’s Guideline, appendix PP to State Operations Manual. Reviewing the survey can provide detailed insight into the kinds and extent of problems the facility experienced. These surveys can be very lengthy and intimidating and are not in a user-friendly format. Moreover, if the survey took place a number of months before the prospective admission, the survey may no longer present an accurate picture of the facility as quality can change rapidly in a facility after a change in management, ownership, etc. In addition, facilities can often anticipate when they are likely to have an annual survey and may take pains to ensure they are looking their best when the surveyors arrive. Similarly, plans of correction are often perfunctory and may not be followed.

[I.] [A.] [1.] Nursing Home Compare website – An extraordinarily valuable source of information for consumers with internet access in HCFA’s (formerly the Health Care Financing Administration, now the Center for Medicare and Medicaid Services or “CMS”) “Nursing Home Compare” website which can be at www.medicare.gov/nursing/home/asp. For each nursing facility that participates in Medicare or Medicaid in the country, the website will provide three types of information.

- a. First, the website will provide basic information about the facility such as its address, the number of beds and if the home is part of a chain of facilities.
- b. Second, consumers can obtain information about the percentage of residents with important characteristics like bedsores, urinary incontinence, unplanned weight loss or gain, etc. Consumers can then compare this information to statistics regarding the nationwide and statewide incidence of those conditions. This information, though useful, is self-reported by facilities and may not be entirely accurate. A high percentage of certain conditions is not necessarily a sign of negligent care (for example, it could indicate a willingness of a facility to accept applicants with heavy care needs that other facilities might reject). However, consumers should at least be curious whether facilities that have a high percentage of residents with these characteristics are providing quality care and should at the very least want to inquire if the facilities have sufficient staff to deal with the highly dependent population they apparently serve.
- c. Third, the website provides information on the facility’s most recent survey and the three previous surveys. The website uses both graphs and words to describe the nature, scope and severity of the deficiency as well as how the number of deficiencies compared to the state and national averages. This

information is in a much more user-friendly form than the surveys themselves, but does not contain the level of detail found in the survey forms.

3. Information regarding complaints – Long Term Care Ombudsman staff have generally been willing to share with consumers information regarding whether they have received a number of complaints about a facility, although they would not share details of those complaints or any information that violated the confidentiality of residents. Consumers can also call the Attorney General’s Office to inquire if it is aware of any complaints or actions against the facility. Licensing Officers at the Department of Consumer and Industry Services may share similar information.

4. Quality Indicator Reports – These reports are available only at the nursing facility and compile data about the incidence of a number of conditions such as urinary incontinence and skin breakdown among the residents. The report also gives comparative data with other facilities. The information in the report is prepared by the federal government based on resident assessments the facility submits to the government. Applicants should be suspicious of facilities that are unwilling to share these reports. Moreover, while a high incidence of certain conditions might not always indicate poor care, those interested in possible admission should inquire why there is a high incidence of certain conditions and whether the facility has sufficient staff to respond to the needs of these residents.

D. Other considerations – Consumers selecting a nursing home should also consider several other important issues:

1. Location – Nothing may be more important to ensuring a resident’s good care and good spirits than frequent visits from friends and family. It is therefore important to select a facility that is accessible and convenient to the people most likely to visit.

2. Source of Payment – A nursing facility can accept Medicare and Medicaid reimbursement only if the facility is federally certified for the appropriate program. *See* 42 U.S.C. § 1395i-3(g)(1)(A) for Medicare certification and § 1396r(g)(1)(A) for Medicaid certification. Most nursing homes do in fact have Medicaid and Medicare certification, but may not choose to accept residents with limited financial resources. If the applicant is eligible for Medicaid or will soon be, it is imperative to find out if the facility has a Medicaid provider agreement and if it will admit a resident with few private resources. If the home is a Medicaid provider, does it have limited bed certification which might mean that a Medicaid bed is not in fact available at the time the resident’s funds are exhausted? It is *essential* to establish this information before selecting a home.

3. Special Services – Some facilities advertise that they provide special services like sophisticated care for residents with Alzheimers Disease or special rehabilitation services. Often these services may in fact amount to no more than the facility is obligated to provide under law as a nursing facility. *See* § IV. But if a resident has dementia or is in need of aggressive rehabilitation or mental health services, it is crucial to establish whether the facility can actually meet the resident’s needs. Failure to determine whether there is a good match between the resident’s needs and the facility’s abilities can lead to disappointed and neglected residents and may lead the facility to seek to discharge the resident in the future.

IV. Legal Issues in the Admission Process

A. Admission to a nursing home can be an overwhelming time for families and new residents who are often faced with a flood of paperwork at a very stressful time. Consumers should never sign anything they do not understand and would be wise to take documents home to review or

seek advice from an attorney.

B. Studies in numerous states have shown that most admissions contracts contain illegal and unenforceable provisions. Consumers can try crossing out and initialing any unacceptable provisions although nursing homes might refuse to accept the resident if the contract is altered. Some consumers have had success trying to negotiate the contract to achieve more favorable terms. These contracts are often contracts of adhesion, however, because there is generally no bargaining between parties; families and residents desperate to obtain placement often feel they have little choice but to sign the document. A guide to spotting illegal provisions in contracts which was prepared by AARP is attached as an appendix to these materials.

C. Common illegal provisions in admissions contracts include:

1. A requirement that a person aside from the resident or his or her legal guardian or attorney-in-fact assume financial responsibility (sign as "financially responsible" party or "guarantor") for the resident. See MCLA § 333.21766 which requires that the contract be executed only between the person seeking admission or the person's guardian or legal representative authorized by law to have access to those portions of the patient's or applicant's income or assets available to pay for nursing home care and the nursing home; see also 42 USC § 1396r(c)(5)(a)(ii); 42 USC 1320a-7b(d)(2); 42 CFR 483.12(d) and Interpretive Guidelines F208 which mandate that a facility cannot require a third party guarantor for payment as a condition of admission or expedited admission to or continued stay in a facility. Persons other than residents who sign the contract must make sure they are not making themselves personally financially responsible. In collection actions against individuals who have signed as responsible parties, however, the defendants can argue that the provisions violate the Nursing Home Reform Law, are deceptive under state consumer protections laws, and that the contract is unenforceable because the "responsible party" received no consideration for assuming financial responsibility. See *Podolsky v. First Healthcare Corp.*, 58 Cal. Rptr. 2d 89, 99 - 104. (Cal. Ct. App. 1996) (holding that guarantor agreements require consideration to be enforceable). Eric Carlson suggests that defendants in such cases also consider filing a cross complaint seeking an injunction barring the facility's continued use and enforcement of the responsible party provision. Eric Carlson, Long Term Care Advocacy, at p. 3-39 (2000).

2. A request for deposits for Medicaid or Medicare applicants, see 42 USCA § 1395cc(a)(1); 42 CFR § 489.22; HCFA's Skilled Nursing Facility Manual §317, or preadmission bedhold fee. See HCFA Pub. 51, Transmittal No. 94-2 (July 1994), Medicare and Medicaid Guide, § 43,155 (CCH).

3. Limitations on facility's obligation to manage residents' money or requirements that facility must handle money. See 42 USC § 1396r(c)(6)(A)(1); 42 CFR § 483.10(c); MCLA § 333.20201(3)(g).

4. Any provision that requires residents to waive any of their rights under Medicare and Medicaid. See 42 C.F.R. § 483.12(d)(1), Interpretive Guideline F208.

[I.] [A.] [1.] Any "duration of stay" requirement which requires the resident to pay privately for a specified period of time even if the resident becomes eligible for Medicaid before the expiration of the period. See 42 C.F.R. § 483.12(d)(3); Interpretive Guidelines F208.

6. Improper language concerning when a resident can be transferred or discharged.

7. A disclaimer regarding liability for injury or harm or loss and theft of personal possessions. See 42 C.F.R. 483.15(h)(1); 42 C.F.R. 483.10(I) ; MCLA 333.20201(3)(c).

8. A requirements that residents accept and pay for services they do not request. See 42CFR § 483.10(c)(8)(3).

[I.] [A.]

Special Issues in Admissions

1. Issues regarding resident capacity – Residents who lack capacity to agree to placement are often placed in facilities even if no one else has the legal authority to admit them. Facilities may try to require that all residents have an attorney-in-fact, guardian, or conservator for the facility’s own convenience and protection, but no resident who does not meet the definition of a person in need of a guardian or conservator should ever be adjudicated incapacitated to serve this facility purpose.

[I.] [A.] [1.] Residents with mental health or mental retardation – Federal law requires applicants to Medicaid -certified nursing homes to be “screened” before admission to determine if they are mentally ill or have mental retardation regardless of their intended source of payment for care. 42 C.F.R. 483.102(a). This “Pre-Admission Screening and Resident Review” (PASRR) process was developed to ensure that residents who need specialized mental health and mental retardation services are not placed in facilities in which they would not receive these services. The process is as follows:

a. The state’s mental health authority is responsible for screening residents with mental illness and the state’s developmental disability authority screens residents who have mental retardation. 42 U.S.C. §§ 1396r(e)(7)(B)(i) and (ii); 42 C.F.R. §§ 483.106(d)(i) and (2).

b. There are two levels of PASRR screens. Level I screens determine if individuals are suspected of having mental illness or mental retardation. See 483.128(a). If an individual is *not* suspected of having one of these conditions, no further screening is required. Moreover, the law makes clear that individuals with a primary diagnosis of dementia should not be considered mentally ill and do not require further screening. 42 U.S.C. § 1396r(e)(7)(G)(i); 42 C.F.R. §§ 483.102((b)(1)(i)(B), 2. Level II screens determine both whether the resident requires nursing facility services and whether he or she needs specialized services for mental illness or retardation. 42 C.F.R. § 483.128(a).

c. If the screen determines the applicant does not require nursing facility services, he or she will not be admitted. 42 U.S.C. 1396r(e)(7)(C)(i)(ii)(iii); 42 C.F.R. § 483.118(a). If the screen determines both that the resident requires nursing facility services and specialized services, the state is responsible for ensuring those services are provided. 42 C.F.R. §483.116(b)(2).

d. Applicants dissatisfied with their PASSR determination may appeal it in a fair hearing. 42 C.F.R. §§431.200, 483.204(a)(1).

[I.] [A.] [1.] Financial discrimination in admissions – Because private rates are higher than Medicaid reimbursement, facilities routinely screen applicants to determine their financial assets and then calculate how long, if at all, the resident will be likely to pay privately for his or her care. Many facilities have an unwritten policy of admitting applicants only if they have sufficient assets to pay privately for a set period of time, e.g. one year. Applicants who refuse to provide the requested information will almost certainly not be admitted. Although HCFA Region V (Chicago) issued a letter in 1992

stating that discrimination against Medicaid-eligible applicants was illegal, *see* Letter from Walter V. Kummer, HCFA Region V, to Richard Yerian, Michigan Dept. of Public Health, (Sept. 1, 1992), the letter was promptly withdrawn, and HCFA's central office alleged it was studying the issue. *See* Letter from Kathleen A. Buto, HCFA Bureau of Policy Development, to Regional Administrators (Jan. 22, 1993). No further guidance has been issued since.

D. Other papers may also be signed at the time of admission. These include an acknowledgment that the resident or family received information on residents' rights, a form permitting the use of restraints, information regarding emergency contacts, and information regarding advance directives. Moreover, pursuant to a new state law, residents upon admission must be offered the option of having bed rails. MCLA § 333.21734.

V.

Resident Assessments and Care Planning

A. Facilities that provide poor care are often cited for failing to adequately assess residents and failing to develop, implement, and evaluate individualized care plans. Assessment and care planning are the building blocks of good care and good quality of life. As a result, federal law is very specific about what kind of assessments and follow-up are required.

B. A nursing facility must complete a full assessment of a resident's condition within 14 days after admission, at least every 12 months thereafter, and "promptly after a significant change in the resident's physical or mental condition." 42 U.S.C. §§ 1395i-3(b)(3)(C)(i), 1396r(b)(3)(C)(i); 42 C.F.R. § 483.20(b)(2). The assessment must include certain information, known as the Minimum Data Set (MDS), 42 C.F. R. § 1395i-3(b)(3)(A)(ii), (f)(6)(A), 1396r(b)(3)(A)(ii), and must be entered on a Resident Assessment Instrument (RAI) which is a standard form generated by HCFA. 42 U.S.C. §§ 1395i-3(b)(3)(A)(iii), (e)(5), 1396r(b)(3)(A)(iii); 42 C.F.R. §483.315(a). A sample form is attached to these materials. The information included concerns topics such as a resident's customary routine, cognitive patterns, communication, mood and behavior, skin condition, etc. 42 C.F.R. § 483.315(e). For each category, the staff member can identify not only the presence of certain conditions or circumstances, but also the degree or frequency of the problem. Certain scores on the RAI result in "triggers" which are meant to both identify problems and assist the facility in care planning to address them.

C. The assessment must be coordinated by a registered nurse and anyone who enters information on the form must sign it. 42 U.S.C. §§ 1395i- 3(b)(3)(A)(i); 1396r(b)(3)(A)(i); 42 C.F.R. §483.20(i)(1); Appendix R to HCFA State Operations Manual, Part III.

D. The assessments are time consuming and complex. It is doubtful that poor facilities that have trouble documenting even simple information will fill out these lengthy and imposing forms with care and thoughtfulness. Nevertheless, facilities transmit MDS information to the state, which passes it on to HCFA. The data is used for many purposes including identifying problems within a facility, detecting nationwide trends, developing appropriate reimbursement rates, etc.

E. Facilities are also responsible for doing slightly less comprehensive assessments on prescribed Quarterly Assessment forms at least every 3 months. 42 C.F. R. § 1395i-3(b)(3)(C)(ii), 1396r(b)(3)(C)(ii). Residents on Medicare must be assessed more frequently. *See* 42 C.F.R. § 483.20(b)(2); 42 C.F.R. § 413.343(b).

F. Facilities must develop a comprehensive care plan for each resident within seven days after the completion of the assessment. 42 U.S.C. §§ 1395i-3(b)(2); 1396r(b)(2); 42 C.F.R. § 483.20(d)(2)(i). The care plan must be developed by an interdisciplinary team consisting of the resident's attending physician, a registered nurse with responsibility for the resident, other appropriate staff members, and the resident or the resident's representative, if possible. 42 U.S.C. §§ 1395i-3(b)(2)(b)(B); 1396r(b)(2)(b); 42 C.F.R. § 483.20(d)(2)(ii). The care plan must set forth the services that are to be provided to the resident *to attain or maintain the highest practicable physical, mental and psychosocial well-being*. 42 U.S.C. §§ 1395i-3(b)(2)(a); 1396r(b)(2)(a); 42 C.F.R. § 483.20(d)(1)(i). It must include a timetable and measurable objectives.

G. Good care planning and energetic implementation and revision of the care plan as appropriate are essential to good care. Facilities should notify residents and families when the care planning meetings are scheduled and attempt to accommodate the schedules to those of the residents and families who wish to attend. *See* Surveyor's Guideline to 42 C.F.R. § 483.20(d)(2), Appendix PP to State Operations Manual. Residents and families need to be forceful to ensure the care planning meetings are more than perfunctory and that the provisions of the care plan are implemented. Residents and families can ask for more frequent care planning if necessary and can also raise concerns at any time.

VI.

Nursing Facility Services

A. Nursing homes are required to provide numerous services which include:

[I.] [A.] [1.] Therapy – The Nursing Home Reform Law requires residents receive physical therapy, speech therapy, occupational therapy, and mental health rehabilitative services sufficient for residents to reach and maintain the highest practicable level of functioning. 42 U.S.C. §§ 1395i-3(b)(4)(A)(i); 1396r(b)(4)(A)(i); 42 C.F.R. § 483.45(a). The facility can provide the therapy in-house or obtain the necessary services from an outside provider. 42 C.F.R. § 483.45(a). Therapy must be provided by qualified staff (not just a certified nursing assistant), Surveyor's Guideline to 42 C.F.R. § 483.45(a), Appendix PP to State Operations Manual, and must be ordered in writing by a physician. 42 C.F.R. 483.45(a). These services must be provided to Medicaid eligible residents as well as to residents with more resources and no fee can be charged to a Medicaid recipient for therapy because it is part of the covered facility services. Surveyor's Guideline to 42 C.F.R. § 483.45(a), Appendix PP to state Operations Manual. Range of motion exercises to prevent contractures must also be provided, if required, but these are generally performed by a nursing assistant and are not a substitute for therapy services if the resident requires them.

[I.] [A.] [1.] Pharmacy services – Each facility must provide necessary medications to residents or obtain them from an outside pharmacy. 42 U.S.C. §§ 1395i-3(b)(4)(a)(iii); 1396r(b)(4)(a)(iii); 42 C.F.R. § 483.60. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. 42 C.F.R. § 483.60. However, if a pharmacist reports irregularities to the attending physician and director of nursing as required, *id.*, the attending physician or nurse may disagree with the pharmacist's conclusion. Surveyor's Guideline to 42 C.F.R. § 483.60(c)(2), Appendix PP to HCFA State Operations Manual.

[I.] [A.] [1.] Dental services – A nursing facility must arrange for all residents to receive dental care. 42 C.F.R. § 483.55. This includes routine and emergency care. If the services are to be provided outside the facility, the facility has to assist in making the appointment and arranging transportation. Id.

[I.] [A.] [1.] Vision and hearing – Residents must have access to treatment and assistive devices necessary for vision and hearing. 42 C.F.R. § 483.25(b).

[I.] [A.] [1.] Special services – Nursing homes must be able to provide certain special services including injections; care for a tracheostomy and tracheal suctioning; care for a colostomy, ureterostomy or ileostomy; administration of oxygen; foot care; care for and use of prostheses; and respiratory care. 42 C.F.R. § 483.25.

[I.] [A.] [1.] Social Services – A facility must provide a wide array of social services including planning for a resident’s discharge, maintaining contact with the resident’s family, assisting residents with financial and legal matters, addressing underlying causes of resident’s behavior, and obtaining necessary services from outside the facility. Surveyor’s Guideline to 42 C.F.R. § 483.15(g)(1). In homes with more than 120 beds, there must be a full-time social worker with at least a bachelor’s degree in social work or a related field and at least one year’s experience. 42 C.F.R. §§ 483.15(g)(2) and (3).

[I.] [A.] [1.] Physician services – Every resident must be under the care of a physician and the facility must always have access to a physician to provide emergency care. 42 U.S.C. §§ 1395i-3(b)(6)(A), (B), 1396r(b)(6)(A), (B); 42 C.F.R. § 483.40. The resident has a clear right to choose his own physician. 42 C.F.R. § 483.10(d)(1), although most physicians in the community are unwilling to visit residents in a nursing home. Thus, residents usually end up with one of the physicians affiliated with the home. The physician must see the resident at least once every 30 days for the first three months and at least once every 60 days thereafter. 42 C.F.R. § 483.40(c)(1). Every facility must also have a medical director who is responsible for coordinating medical care in the facility and overseeing the implementation of resident care policies. 42 C.F.R. § 483.75(i)(1) and (2).

[I.] [A.] [1.] Nursing Services – A facility must have sufficient nursing staff to meet residents’ needs and must meet both state and federal staffing requirements. Federal law requires that a facility have a licensed nurse on duty around the clock and employ a registered nurse at least eight hours a day, seven days a week. 42 U.S.C. §§ 1395i-3(b)(4)(C)(i); 1396r(b)(4)(C)(i); 42 C.F.R. §483.30(a),(b). A licensed nurse must serve as a charge nurse each shift and a registered nurse must serve as a full-time director of nursing. 42 C.F.R. § 483.30. *See* also, MCLA 333.21720a. Pursuant to state law, residents shall receive not less than 2.25 hours of nursing care per day (which includes care by nursing assistants) and the ratio of nursing staff (including nursing assistants) to residents shall not be more than 1 to 8 on the day shift, one to twelve on the evening shift, and one to 15 on the night shift. Id. As a practical matter, the vast

majority of care in the facility is provided by nursing assistants. Licensed nurses are often tied up with administrative duties and spend much less time performing hands-on care.

VII.

Residents' Rights

A. Residents' rights are spelled out in both state and federal law. Rights assured by state law are found in MCLA § 333.20201 and include:

1. The right to needed and authorized care and treatment including the right to adequate and appropriate care without discrimination, right to refuse treatment, knowledge of who is responsible for care, freedom from restraints except in certain limited circumstances, participation in care planning, and limitations on discharge

2. Rights to information including information about charges, facility procedures, and right to inspect and copy (for a reasonable fee) records.

3. Rights to self-determination and dignity including rights to treatment with dignity, consideration and respect; right to exercise rights of citizenship; pursuit of grievances against facility; religious freedom; freedom of association with others; private communication with others; retention of personal possessions; privacy and confidentiality, etc.

B. Federal law grants many of the same rights, often in stronger language, and also mandates the following rights for all residents living in a Medicaid or Medicare certified facility, regardless of their individual source of payment (See 42 USC § 1396r(c) and 42 CFR § 483.10):

1. the right to choose an attending physician;
2. right to be free of involuntary seclusion and corporal punishment;
3. right to receive services with "reasonable accommodation of individual needs and preferences";
4. notice before roommate change;
5. right to organize a family council;
6. the right to return to the next available bed in a semi-private room after hospitalization;
7. prohibition on right of facility to restrict access to Medicaid or Medicare coverage and benefits; and
8. right to refuse room transfers in certain circumstances.

C. Common Rights Violations

[I.] [A.] [1.] Quality of Care and Life – federal and state law are full of requirements for high quality care and life in the facility including the language, "Each resident must receive and each facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." 42 CFR § 483.25. However, it is hard to get reality to match the promise of the law. One of the best places to start is at the care planning conference which must occur, as noted above, at least quarterly (and more often if necessary or requested) with an interdisciplinary team of

care providers. Families and residents have the right to attend and this is a good place to lay out problems and concerns.

2. Restraint Use – Some facilities are now restraint free and facilities in many countries never used restraints at all. OBRA '87 (the Nursing Home Reform Law) severely restricted the use of restraints and made restraint reduction a priority. Several studies have determined that the law was effective in this regard and that restraint use has declined significantly across the country since the law was passed.

[I.] [A.] [1.] [1.] State law provides that chemical and physical restraints cannot be used unless authorized in writing by a physician for a specified and limited period of time or in an emergency to protect residents from injury. In those emergency situations, the restraint must be applied by a qualified person, it must be noted in the resident's record, and the physician must be notified promptly. MCLA § 333.20201(2)(1).

[I.] [A.] [1.] [1.] Federal law provides that restraints cannot be imposed for discipline or the convenience of the staff and that, except in an emergency, the physician must specify the duration and circumstances under which the restraints can be used. 42 USC § 1396r(c)(1)(A)(ii), 42 CFR § 483.13(a). Prior to seeking consent, the facility must explain the potential negative consequences of restraints including decreased range of motion, decreased ability to ambulate, symptoms of withdrawal and depression, and reduced social contact. Surveyor's Guideline to 42 C.F.R. § 483.13(a), Appendix PP to HCFA State Operations Manual.

NB: Bed rails are considered a type of restraint and the issue of bed rails has received significant attention in the state in the last year. While many people view bed rails as a benign safety device to limit residents' falls from bed, numerous individuals have been hurt or died as a result of injuries involving bed rails. These injuries include individuals who have been asphyxiated when their heads or bodies became entrapped in bed rails or who suffocated when their heads became entrapped between their mattress and the bed rail and falls that have been more severe because residents climbed over bed rails before falling to the floor. Alternatives to bed rails such as lowering beds closer to the floor, providing contoured mattresses, better monitoring of residents at risk of falling, etc. can eliminate the need for bed rails in many cases. If bed rails are used, it is crucial that the mattress, bed, and rails fit precisely together and that other safety rules are observed. Michigan law requires that new residents be offered the option of bed rails upon admission and that those requesting bed rails be advised of the risks of and alternatives to them. MCLA § 333.21734. Residents who request bed rails must sign a consent form and the resident's attending physician must write an order that describes the resident's symptoms and specifies under what circumstances the rails can be used. *Id.* The "medical symptoms" that can apparently justify an order for bed rails are both vague and broad. The nursing home is responsible for documenting that the requirements of the law have been met and monitoring the resident's use of bed rails *Id.* In the spring of 2001, the Department of Consumer and Industry Services issued Interim Guidelines regarding safety protocols for bed rail usage.

C. Limits on Visiting Hours – Nursing homes often try to limit visiting hours or suggest strongly that visitors only come during certain times. Even the MDCH publication, "Know Your Rights[:] Your Medicaid Care and Coverage in a Nursing Home" suggests that visiting hours can be limited to 8 hours

a day in the absence of special circumstances. MSA Publication 731 (Rev'd 2/01) at. 6 However, 42 C.F.R. § 483.10(j) spells out that the resident has the right to immediate access at any time to any representative of the Secretary of HHS and the state licensing agency, the resident's individual physician, the long term care ombudsman, and representatives from the state Protection and Advocacy agency. Moreover, subject to the resident's right to deny consent, the resident may see immediate family or other relatives at any time, and, subject to reasonable restrictions, other who are visiting with the consent of the resident. Moreover, there must be reasonable access to any resident by any entity or individual that provides health, social, legal or other services to the resident, subject to the resident's right to deny consent.

D. Theft or Loss of Property – This very common problem is hard to attack. There is limited statutory language that suggests the nursing homes have an obligation to safeguard personal property (e.g. MCLA § 333.20201(3)(c): resident has the right to "retain" personal property and under federal regulations, the facility must develop and implement written policies that prohibit the misappropriation of resident property, 42 C.F.R. § 483.13(c).)

[I.] [A.] [1.] Residents and families should inventory and label all property upon admission and periodically thereafter. Valuables should not be kept in the facility unless given to the administration for safekeeping. If family does the resident's laundry, loss of clothing is much less likely.

2. Claims for lost or stolen property can sometimes be made against resident's homeowner's insurance or facility insurance; facilities will sometimes reimburse if given a written request for reimbursement. Also, claims can be made in Small Claims Court.

E. Failure to Accommodate Individual Resident Needs: The Assembly Line

Mentality of Many Facilities – As noted above, federal law provides the resident has the right to receive services with reasonable accommodation of individual needs and preferences, 42 CFR § 483.15(e), and the resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care. 42 CFR § 483.15(b)(1). This right should be enforced to allow residents to have appropriate meals when they like and bedtimes and bathtimes at times that suit them, and to seek appropriate activities. If facilities say that they do not have enough staff to accommodate individual

preferences, they need to hire more staff! This requirement is very important to residents.

F. Inadequate Staffing – Understaffing is an extremely common problem at the heart of inadequate care. State law requires extremely minimal staffing; the staffing requirements were enacted 40 years ago when nursing home residents rarely had problems as acute as they now have. *See* MCLA § 333.21720a(2) which requires 2.25 hours per resident per day. Most nursing homes staff well above the state minimums even though they are still understaffed to meet the needs of their residents (e.g. the statewide average is now over 3.0 hours per day). Staffing on weekends, evenings and holidays is particularly bad and facilities often rely on temporary agency or "pool" staff to fill in. The use of pool staff who are unfamiliar with and to the residents and unaware of facility protocols can have a particularly deleterious effect on residents' care and lives.

VIII.

Involuntary Transfers and Discharges

A. Intrafacility transfers – Residents may refuse intrafacility transfers only if the transfer is because of a change in the resident’s Medicare payment status. For example, a resident can refuse to move into the Medicare unit of a facility when he or she becomes eligible for Medicare or may refuse to move out of the Medicare unit when Medicare eligibility ends. The refusal to move does not affect the resident’s eligibility for or entitlement to Medicaid and Medicare benefits. *See* 42 CFR § 483.10(o). Michigan facilities rarely advise residents of this right and routinely ignore it.

B. Allowable Reasons for Involuntary Transfer or Discharge, Hearings and Procedure – For an extensive discussion of this subject, *see* Outline and materials prepared by Eric Carlson and Alison Hirschel for the June, 2001 Joint Training of the Michigan Poverty Law Program and the Long Term Care Ombudsman Program.

C. Bedholds – Under a new policy, Medicaid will reimburse a facility to hold a bed for a resident for up to ten days if a Medicaid resident is temporarily absent from the facility for an emergency hospital admission. Medicaid will also reimburse a facility to hold a bed for up to 18 days a year if a Medicaid resident is on therapeutic leave. *See* MDCH Bulletin issued 1/1/2001 (Long Term Care Facilities 00-05). This guarantees residents who qualify for hospital leave or therapeutic leave the right to return to the *same* bed upon their return to the facility. For residents who must leave the facility temporarily but who do not qualify for hospital leave or therapeutic leave days under the Medicaid program, facilities are required to permit residents to pay to hold their bed until their return. MCLA § 333.21777

D. Right to return after a hospitalization or therapeutic leave – Federal law requires that Medicaid and Medicare certified facilities permit residents who did not pay to hold the bed to return to the first available bed in a semi-private room in the facility once the resident is ready to return. 42 U.S.C. § 1396r(c)(2)(D); 42 C.F.R. § 483.12(b). This right to return exists even if the resident has an unpaid bill at the facility. 56 Fed. Reg 48,826, 48,841 (1991). However, it is sometimes difficult to ascertain if the facility really does have a bed or not and residents may sometimes have to be placed elsewhere even if they still wish to return to the next available bed at the original facility whenever it becomes available.

IX. The Question of Quality

A. Many facilities provide compassionate, responsible, high quality care. These facilities have adequate numbers of well-trained staff, a home-like environment, and a commitment to assuring quality care and a dignified life for their residents. But the existence of these fine facilities, including facilities that are committed to the Eden Alternative, does not negate the fact that a multitude of facilities across the state provide substandard care in sometimes harrowing conditions. Each year, the Department of Consumer and Industry Services produces thousands and thousands of pages of survey reports, carefully detailing countless incidents of physical and emotional abuse, malnutrition, dehydration, avoidable pressure (bed) sores, unexplained injuries, and a host of other examples of neglect and abuse. Indeed, until very recently, Michigan surveyors routinely cited Michigan facilities at close to twice the national average (e.g, in 1999, Michigan facilities were cited for an average of 9.63 citations per survey, the third highest in the country, while the national average was only 5.51 citations per survey. “Nursing Homes at a Glance, Michigan Department of Consumer and Industry Services, Feb. 4, 2000). When facilities challenge these findings before an independent review panel, that organization overwhelmingly supports the state’s findings. When federal surveyors follow up on state surveyors’ findings to ensure consistency in surveys across the region (“validation surveys” discussed below), they overwhelmingly agree with state surveyors’ determinations. And the violations observed by surveyors are obviously only a tiny percentage of the violations that actually occur.

B. The media and other governmental organizations have meticulously documented poor care as well.

For example, just last month, a report prepared by Minority Staff of the U.S. House Committee on Government Reform for Rep. Henry Waxman documented that in the two year period between January 1999 and January 2001, thousands of nursing homes across the country were cited for abuse violations. "Abuse of Residents is a Major Problem in U.S. Nursing Homes," Minority Staff, Special Investigations Division, Committee on Government Reform, U.S. House of Representatives, July 30, 2001 at i. The study found that many of the violations caused harm to residents and that the percentage of nursing homes with abuse violations is increasing. *Id.* at i-ii. Moreover, the report identified many instances of physical, sexual and verbal abuse which it labelled "appalling." *Id.* at ii. The U.S. General Accounting Office has also produced a number of detailed reports in the last few years, some including Michigan-specific information, identifying severely substandard care and problems in state efforts to enforce federal law. *See, e.g.*, General Accounting Office, Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality, GAO/HEHS-00-6 (1999) and General Accounting Office, Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards, GAO/HEHS-99-46 (1999). Similarly, Sen. Charles Grassley has spearheaded numerous hearings and reports of the U.S. Senate Special Committee on Aging documenting poor care across the country and sometimes specifically identifying problems in Michigan facilities. And the media frequently documents particularly egregious cases.

C. The problem with regulation – Nursing homes are an extremely highly regulated and complex industry. Industry representatives frequently complain that complying with unnecessary regulations raises costs, diverts staff time and resources from providing care, interferes with the providers' own quality initiatives, and creates an antagonistic atmosphere between regulators and providers. Advocates fear that the failure to enforce existing laws vigorously has contributed to the continuing substandard care so many facilities provide.

X. Survey and Enforcement of Nursing Homes

A. The Nursing Home Reform Law of 1987, also known as "OBRA '87," Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, 42 U.S.C. §§ 1395i-3 et seq. and 1396r et seq., is an incredibly sweeping and detailed effort to improve the quality of care and life in nursing homes. It and the regulations and policy guidelines that have followed it set forth in tremendous detail how the state and federal government are to assure compliance with the requirements of the law.

B. In Michigan, the agency responsible for conducting surveys of nursing homes to determine compliance with state licensure and federal certification requirements is the Michigan Department of Consumer and Industry Services, Bureau of Health Systems. That Bureau is divided into a number of Divisions including:

[I.] [A.] [1.] [1.] The Division of Operations, directed by Michael Dankert, which includes the Complaint Intake Unit; the Complaint Investigation Unit; the Enforcement Unit which is responsible for processing, tracking and coordinating enforcement actions; the Training Unit which is responsible for ensuring a comprehensive program of staff training, professional development, and an understanding of state and federal requirements, and the Data Management Unit which responds to Freedom of Information Act requests as well as performing other duties.

[I.] [A.] [1.] [1.] The Division of Nursing Home Monitoring, headed by Celeste

Meriweather, which, according to the CIS/BHS website, “serves to protect the health and safety of individuals receiving care in long term care facilities (nursing homes, hospital long term care units, and county medical care facilities) through the development, monitoring and enforcement of surveys and evaluations to comply with licensure and certification standards; to provide technical assistance to facilities in meeting those standards; to investigate residents’ complaints; pursue appropriate corrective action of facility deficiencies; and to license and recommend certification for Medicare and Medicaid with the overriding emphasis of all of these actions being to assure and improve the quality of life and quality of care for health facilities’ residents, patients and other users of applicable services.”

C. Surveys – Although the state performs most surveys, in at least five percent of the state’s nursing homes, HCFA conducts a follow-up survey, called a “validation survey,” to ensure the state survey agency performed appropriately. 42 U.S.C. §§ 1395i-3(g)(3)(B); 1396r(g)(3)(B). Surveys are conducted around the state by six multi-disciplinary survey teams, each headed by a Licensing Officer. “Michigan Nursing Homes at a Glance,” Michigan Department of Consumer and Industry Services, Feb. 4, 2000. In addition to the validation surveys, there are four other types of surveys:

1. Annual or Standard Surveys – Facilities must be surveyed at least every 15 months and, statewide, the average frequency of surveys of facilities must be at least once every 12 months. 42 U.S.C. §§ 1395i-3(g)(2)(A)(i), (iii); 1396r(g)(2)(A)(i), (iii), 42 C.F.R. § 488.307(a). Surveys must be unannounced, 42 U.S.C. §§ 1395i-3(g)(2)(A)(i),); 1396r(g)(2)(A)(i), 42 C.F.R. § 488.307. Nevertheless, facilities can often guess when they are likely to be surveyed and can put their best foot forward at that time. Many residents and families report significant changes in staffing and the appearance of the facility when management anticipates a visit from the surveyors. While surveys are generally conducted during the day, an initiative by President Clinton required that at least 10 percent of all surveys be conducted at night and weekends. HCFA State Operations Manual §§ 2704, 7207(B). Survey teams are multidisciplinary and include at least one registered nurse. 42 U.S.C. §§ 1395i-3(g)(2)(E)(i), 1396r(g)(2)(E)(i). Surveyors review numerous aspects of the facility including a pre-selected sample of residents.

[I.] [A.] [1.] Extended Surveys – If the annual or standard surveys identifies substandard quality of care deficiencies (those citations which demonstrate a serious violation of certain quality of care requirements), a more extensive survey must be completed within 14 days. 42 U.S.C. §§ 1395i-3(g)(2)(B)(ii), 1396r(g)(2)(B)(ii); 42 C.F.R. § 483.310(c).

[I.] [A.] [1.] Complaint Investigations – MDCIS must also be able to conduct surveys in response to complaints received. Some of the complaints might be held until the next scheduled survey; some might require independent visits. Timetables and procedures for investigating complaints are set forth in federal guidelines, *see* HCFA State Operations Manual § 328(E)(1), and the MDCIS Bureau of Health Systems Complaint Investigation Manual.

[I.] [A.] [1.] Life Safety Code inspections, often conducted at the same time as annual surveys, to check for building safety issues like fire and electrical hazards.

C. Deficiencies – Violations cited by surveyors are called “deficiencies” and are identified on a federal form known as “HCFA Form 2567” or the “Statement of Deficiencies and Plan of Correction.” That form contains a great deal of information including the names of the surveyors, statistical data about the facility, columns for the federal “tag number” (“F-tag”) from the Surveyor’s Guidelines which identifies the regulation alleged to have been violated, a description of the requirement and documentation of the facts supporting the citation, space for the facility’s response or “Plan of Correction” and a letter indicating the scope and severity of the deficiency. “Scope and Severity” are identified according to an enforcement grid with 12 squares. The lowest level of severity (letters A, B, C) are for citations in which no actual harm occurred; followed by letters D, E, F for violations with the potential for harm; letters G, H, I for violations involving actual harm; and letters J, K, and L for violations that rise to the level of immediate jeopardy. The scope of the violation is determined to be either an isolated incident (letters A, D, G, and J), a pattern of harm (letters B, E, H, and K) or widespread harm (letters C, F, I, and L).

D. Substandard Quality of Care citations– A “substandard quality of care” citation or “SQOC” occurs when facilities are found to have violated the Resident Rights and Facility Practices, 42 C.F.R. § 483.13; Quality of Care, 42 C.F.R. § 483.25; or Quality of Life, 42 C.F. R. § 483.15, provisions and when the violation constitutes immediate jeopardy (letters J, K and L on the grid), a pattern of or widespread actual harm (letters (letters H or I on the grid), or a widespread potential for harm (letter F on the grid). SQOC citations are significant and have consequences including triggering an extended survey.

E. Plans of Correction – Facilities must submit a plan of correction for violations. These plans of correction must include how the corrective action will be taken in relation to the residents affected by the violation, how the facility will identify other residents at risk of the violation, what systemic change will be made to ensure the violation does not recur, how the facility will monitor corrective actions and when the corrective action will be completed. HCFA State Operations Manual § 7304(D).

[I.] [A.] Sanctions – Facilities that have no citation above a letter “C” are considered to be in substantial compliance. For more serious violations, the state or HCFA must determine an appropriate sanction. If a facility has only Medicaid certification, the state may select a remedy within the federal framework. 42 C.F.R. 488.330(a)(1)(i)(C). For facilities with Medicare certification, MDCIS recommends remedies to HCFA, but that agency makes the final decision and notifies the facility of the penalty to be imposed. The permissible sanctions are divided into categories and must be applied by the state agency and HCFA according to the scope and severity of the violation. Category 1 remedies are directed in-service training, state monitoring, and directed plan of correction. Category 2 remedies are denial of payment for new admissions, denial of payment for all individuals, and some civil monetary penalties. Category 3 remedies are temporary management, termination from the Medicaid and Medicare programs, and more severe civil monetary penalties (between \$3,050 and \$10,000 per day, or between \$1,000 and \$10,000 per instance). 42 C.F.R. §§ 488.408(e)(2)(ii), 488.430, HCFA State Operations Manual §§7308(A). If a facility is cited for a level D violation, the survey agency must impose a Category 1 remedy and may impose a Category 2 remedy. If a facility is cited at a level G, the agency must impose a Category 2 remedy but may also select a Category 1 remedy. If a facility has a citation constituting immediate jeopardy, the agency must impose a Category 3 remedy but may also impose level 1 and 2 sanctions.

[I.] [A.] Opportunity to Correct – In most cases, the facility is given an opportunity to

correct and no penalty is incurred if the citation is corrected in a reasonable period of time. Facilities are not given an opportunity to correct if there is immediate jeopardy or if they have a “double G” which means a citation at level G or above on the current and previous standard survey or the current survey and any survey conducted since the last standard survey. HCFA State Operations Manual, §§ 7304(a),(b), 7313(B).

[I.] [A.] Revisits – Although the state will sometimes accept a facility’s “attestation” of compliance with a plan of correction approved by the state, it will often conduct revisits to determine compliance. If a facility remains out of substantial compliance for 180 days, federal law requires it be terminated from the Medicare and Medicaid programs. 42 U.S.C. §§ 1395i-3(h)(2)(C), 1396r(h)(3)(D). Such terminations often lead to facility closures.

[I.] [A.] Facilities may dispute survey findings in an informal dispute resolution process (IDDR). HCFA State Operations Manual § 7212(B). This process involves a paper review of material submitted by the facility and the department and is conducted by the Michigan Peer Review Organization (MPRO). Citations can be supported in full, amended, or deleted, but the determination only rarely results in a change in sanctions to be imposed and most citations are supported. For example, in 1999, 18 percent of 3,919 citations were submitted to IDDR for review and 79 percent were supported in full. “IDDR99,” prepared by the Department of Consumer and Industry Services, 1999. None of the amendments or deletions resulted in a change in enforcement. Id. The 149 citations that were amended or deleted in IDDR represented only 3.8 percent of all citations issued that year. Id. Facilities may also appeal in an administrative law hearing certain state and federal actions including a termination, the assessment of a federal remedy, a finding of substandard quality of care, etc.

[I.] [A.] Terminations and license revocations – Terminations and license revocations are very rare. Significant violations can trigger a “lock-out” which prohibits the facility from conducting required training for nursing assistants on the premises for a period of time. In the last few years, MDCIS has started to rely on the Michigan Public Health Institute (MPHI) to provide technical assistance, training, and management of facilities that have serious violations. MPHI provides directed in-service trainings, helps facilities with directed plans of correction, provides clinical advisors, and serves as temporary managers or closure agents in very troubled homes. While the state can direct facilities to purchase MPHI’s services, the facility must pay for the services itself. MPHI then provides on-site assistance that can range from an occasional visit to provide training to full-time presence in the facility for a period of months.

[I.] [A.] Efforts have been made at both the federal and state level to identify particularly poorly performing facilities to facilitate more frequent surveys and to select appropriate remedies. (Examples include the Clinton Initiative requirement that each state select two “poor performing” homes for additional oversight, HCFA’s development of quality indicators based on MDS data, the state’s scoring system that looks at survey and complaint information regarding each of the state’s homes to determine which facilities are outside the

norm for violations.) President Clinton's initiative also included a push to identify patterns of violations in nursing home chains. Nevertheless, many homes have exhibited cyclical patterns of serious and repeated violations for years – these homes are often cited for very severe violations, but manage to improve sufficiently to avoid termination. However, once the regulatory heat is off, the facilities slide right back into previous patterns and are often cited for many of the same violations at the next survey.

XI.

Resolving Residents' Complaints

A. Resolving Concerns in the Facility – Residents and their families and advocates should generally try resolving concerns in the facility before seeking intervention of outside agencies. Residents may want to seek outside intervention initially if they have a strong fear of retaliation, have experience that suggests their concerns will not be resolved by the facility, are unsure of their rights, or face urgent difficulties. To resolve a complaint inside the facility, the resident can pursue several courses of action:

[I.] [A.] [1.] Learn the chain of command in the nursing home and who is responsible for what. Contact the appropriate person to raise concerns. If this does not resolve the concern, the resident may wish to go up the chain of command to bring the concern to the charge nurse, director of nursing, administrator, or other appropriate management staff.

[I.] [A.] [1.] Learn the facility's procedure for resolving grievances. Is there a standard complaint form that the facility wishes residents to use? Is there a written policy for resolving concerns raised in this manner?

[I.] [A.] [1.] Bring issues of concern to family council or resident council meetings, if they occur, and use these groups to resolve concerns, especially those that affect large numbers of residents (such as food temperatures or rough treatment by staff).

[I.] [A.] [1.] Ask for a care conference and seek solutions through that process. Make sure the facility documents in detail the care plan to which the parties agree and that it is implemented as written.

B. Filing complaints with the Michigan Department of Consumer and Industry Services – Residents who have not been able to resolve complaints satisfactorily in the facility may wish to file a complaint with the Michigan Department of Consumer and Industry Services. MDCIS's Complaint Investigation Amanual is attached as an appendix to these materials.

1. Written and oral complaints – The Department operates a toll-free hotline which may be reached 24 hours a day from anywhere in Michigan an **1-800-882-6006**. Callers will be able to leave a message after business hours or speak to a member of the Complaint Intake Unit between 8 a.m. and 5 p.m. Monday to Friday. Previously, the Department was reluctant to accept oral complaints and slow to assist consumers in reducing the complaint to writing. *See* MCLA § 333.21799a and R. 325.20114(3). The Department now pledges to handle these calls more efficiently. Complaints may be filed by completing a Resident Care Complaint form (BHS-OPS-361) which can be obtained on-line at the Bureau of Health Systems website, www.cis.state.mi.us/bhs/ops/intake or

sending a letter to the Bureau containing the name and address of the facility, the nature of the complaint, the date of the incident, and the complainant's name, address, and a daytime telephone number. Written complaints still assure complainants of the best response; they should be submitted to the **Department of Consumer and Industry Services, Bureau of Health Systems, Complaint Intake Unit, P.O. Box 30664, Lansing, MI 48909**. The more detailed and well-documented the complaint is, the better the chance the Department will substantiate it upon investigation. Complaints may be made anonymously. R. 325.20114(4). A complaint must be filed within 12 months of the alleged violation or if a complaint has been filed with the nursing home, within 12 months of the determination of the nursing home. R. 325.20114(1)(a) and (b). The Department hopes to be able to accept complaints on-line in the near future.

2. Rights of Complainants – MCLA § 333.21799a(3) provides that a complaint, a copy of the complaint or a record disclosed about a complaint shall not disclose the name of the complainant or a resident named in the complaint unless the complainant or resident consents in writing to the disclosure. If disclosure is essential to the investigation, the complainant will be given an opportunity to withdraw the complaint before disclosure. *Id.* Moreover, both state and federal law protects residents from retaliation or discrimination because the resident exercised his or her right to raise grievances. MCLA § 333.20201(4); 42 C.F.R. §§ 483.10(f).

3. MDCIS procedures – Upon receipt of a complaint, the Complaint Intake Unit determines whether a state licensing law or rule or a federal certification requirement has been violated and whether the complaint should be referred to another agency. MDCIS Complaint Investigation Manual, Part 3, at 1. The Department will send an acknowledgment of receipt of a complaint to the complainant with the assigned complaint number and information regarding which licensing team and Licensing Officer will be responsible for investigating the complaint.

4. Prioritizing complaints and investigation timelines – Complaints are divided into priorities. The most urgent complaints, such as those involving elopement of a resident or a resident missing for more than 8 hours, life-threatening injury, or sexual assault are considered Priority One complaints and require an on-site investigation within 24 hours. Complaint Manual at 1-2. (However, the Complaint Manual also states that the most serious complaints must be investigated within 2 working days of receipt. *Id.* at 5.) According to the Department Manual, complaints will be investigated within 30 days but the complaint may be held until the next standard survey. *Id.* at 2; state law requires that complaint investigations be commenced within 15 days of the receipt of the complaint and resolved within 30 days of receipt of the complaint. MCLA § 333.217799a (4) and (6). And HCFA requires that all complaints alleging actual harm be investigated within 10 days and those alleging immediate jeopardy be investigated within 2 days. “Dear Survey Agency Director” letter from Rachel Block, Oct. 15, 1999.

5. Complaint protocols – Complaints are generally investigated by a single surveyor who reports to a Bureau of Health Systems Licensing Officer. On-site visits pursuant to complaint investigations must be unannounced. *See* MCLA § 333.21799a(2); Complaint Investigation Manual Part 3, p. 6. Before the on-site investigation, the surveyor should review the complaint and supporting documentation, review the pertinent regulatory provisions, check the facility history, contact the Ombudsman to inquire if other similar complaints have arisen, and plan the investigation. *Id.* Once in the facility, the surveyor should review relevant documentation, interview appropriate staff and residents or other potential witnesses as well as the complainant, and conduct an exit interview with facility staff at the conclusion of the investigation to outline preliminary findings. *Id.* at 6-9. The Complaint Investigation provides specific guidance for specific concerns such as pressure sores, staffing, lack of heat, etc. When the investigation

has been completed and a final determination made, the Department will send written notification to the facility and the complainant of each of the allegations and whether or not they were substantiated. If the complaint was substantiated and resulted in citations, a HCFA Form 2567 will be created.

6. Complainant rights after the completion of a complaint investigation – If the complaint investigation determined that the resident’s rights were violated, the facility shall be ordered to pay the resident \$100.00 or to reimburse the resident for injuries sustained and costs incurred, whichever is greater, and to pay the Department a civil penalty not to exceed \$1500 or \$15 per patient bed, whichever is lesser. MCLA § 21799c(4). A complainant who is dissatisfied with the investigation or findings may request a hearing within 30 days after the MDCIS mails its findings from the investigation. MCLA § 333.21799a (9). These hearings will generally be limited to the issue of whether the Department erred in the conduct of its investigation or in its conclusion. One unusual aspect of these hearings is that the facility usually appears as the respondent and the resident appears as the complainant, but the party whose actions are at the heart of the hearing – MDCIS – is usually not present. The best result for a complainant is generally that the complaint be reinvestigated; there is some dispute whether the hearing officer can actually direct the Department to issue a citation.

7. Problems with complaint investigations – In 1999, the General Accounting Office (GAO) documented serious problems with Michigan’s complaint investigation process. According to the GAO data, the state sometimes delayed investigating very serious complaints for as much as a year and had a backlog of hundreds of complaints awaiting investigation. After significant negative publicity about this problem, the Department made energetic efforts to clear up its backlog and made changes to improve its ability to investigate complaints promptly. However, some observers expressed concerns that subsequent complaint investigations were insufficiently thorough. In general, the state substantiates only about 25 percent of the 2,500 complaints received each year. “Michigan Nursing Homes at a Glance,” Michigan Department of Consumer and Industry Services, February 4, 2000. Frequently, surveyors note that a violation may have occurred but that the surveyor was unable to document it. For example, if a resident complains that he was illegally restrained, but he is not restrained on the day of the survey and there is no notation in the clinical record concerning restraint use, the surveyor would generally not be able to substantiate the complaint. If residents allege their call bells were not answered for exceptionally long periods of time or that staff treated them roughly, but the surveyor does not observe these situations on the day of his or her visit, the complaint will not be substantiated. It is particularly difficult to substantiate complaints when the alleged victim is incapacitated or may have died, and the staff in question may not, given the high turn-over rate in facilities, continue to be employed at the facility at the time of the investigation. The more time passes, the less likely it is that a complaint will be substantiated.

8. Key contact people regarding complaints – The key contact people at the Department regarding complaints are the surveyor assigned to investigate the complaint, the licensing officer to whom the surveyor reports, and Michael Dankert, the head of the Division of Operations. Mike can be reached at (517) 241-2650 or Michael.E.Dankert@cis.state.mi.us and is very responsive and helpful. Walter S. Wheeler is the Director of the Bureau of Health Systems and can be reached at 517-241-2632. The Complaint Investigation Unit can be reached at 517-241-4712 or by fax at 517-241-0093.

C. Other options and resources regarding complaints – Appropriate complaints regarding nursing homes may be filed with several other agencies.

[I.] [A.] [1.] Health Care Fraud Division, Michigan Department of the Attorney General – This division of the Attorney General’s office is charged with investigating and prosecuting health care providers who are defrauding the Michigan Medicaid program and allegations of patient abuse – which may include sexual abuse, physical abuse, financial exploitation, etc. – in any Michigan facility that receives Medicaid funds. When the Health Care Fraud division receives a complaint, it is screened by an investigator to determine if the alleged occurrence is serious enough to merit possible criminal prosecution. If the complaint does have the requisite level of seriousness, an investigator will interview witnesses, seek documents, etc. If there is an allegation that a resident has been injured, an investigator might visit the facility promptly and take photographs to preserve evidence of the injuries. Most prosecutions are for misdemeanors pursuant to MCLA § 333.21771(1) which provides that a “licensee, nursing home administrator, or employee of a nursing home shall not physically, mentally, or emotionally abuse, mistreat, or harmfully neglect a patient.” Employees may also be charged with felonies such as criminal sexual conduct or involuntary manslaughter. To file a complaint concerning medicaid fraud or patient abuse, residents and their advocates can call **1-800-242-2873**, write to **Health Care Fraud Division, Michigan Department of Attorney General, P.O. Box 30218, Lansing, MI 48909-7979** or file a complaint on-line at www.ag.state.mi.us

[I.] [A.] [1.] Office of Civil Rights of the U.S. Department of Health and Human Services – This agency is responsible for enforcing federal anti-discrimination law against health care and human services providers that receive federal Medicaid or Medicare funds. One of the laws it is responsible for enforcing is the Rehabilitation Act of 1974, 29 U.S.C. § 794 which prohibits providers such as nursing homes that receive federal funds from denying individuals with disabilities the right to participate in or benefit from programs, services, or other benefits, or access to programs, services and benefits. Complaints should be made in writing within 180 days of the alleged discriminatory act and can be sent to: **Office for Civil Rights, 105 W. Adams Street, Chicago, Illinois, 60603.**

XII.

Nursing Home Closings

A. Many nursing homes around the country have closed or at risk of closing. These closings occur because of “performance closures” or involuntary closures by the state when the facility has failed to correct serious violations or because of voluntary closures due to financial factors, providers’ desire to get out of the nursing home business, providers’ realization that they will not be able to bring a home into compliance and will face involuntary closure in the future, and other reasons. Because five major nursing home chains in the country, as well as a host of smaller nursing home businesses, are in bankruptcy, observers fear more nursing homes might be closed. In Michigan, Reginald Carter of the Health Care Association of Michigan, the for-profit nursing home trade group, had predicted dozens of voluntary closures in the future while state officials have predicted a smaller number of homes are likely to close.

B. The state has developed an interagency agreement on nursing home closings that divides up responsibility for dealing with closures. Generally, the Family Independence Agency (FIA) has primary responsibility for moving residents out of the facility. Unfortunately, FIA staff may not be particularly familiar with the quality of care in other homes and other issues relating to nursing home care which are crucial in assuring good discharge plans and a smooth transition to new facilities. In many case, the Michigan Public Health Institute is appointed as the “closure agent” to oversee the closure of the facility. In many cases in the past, the State Long Term Care Ombudsman has played a vital role in advocating for residents, answering residents’ and family questions, and providing information about alternate facilities.

[I.] [A.] Closures generally create a crisis mentality that makes good discharge planning very difficult. When staff realize a home is closing, many leave immediately to seek other jobs, thus leaving residents with even less care during their final days in the home. Families often panic because they believe there are only a few good beds available in the vicinity and it is urgent to grab those beds as soon as possible. Residents are often transferred to other substandard facilities and may even go to homes that are themselves at risk of closure. In the rush to discharge residents, many important details may be overlooked. These include ensuring all the residents’ possessions, medical records, and any funds held by the facility in the patient fund account leave with the resident and that the resident’s medications and durable medical equipment are either transported with the resident or available at the new facility immediately upon the resident’s arrival.

[I.] [A.] Ideally, the number of residents transferred out of a facility on a particular day should be quite limited and the number of residents accepted into another facility each day should be limited. Otherwise, the discharge is likely to be less efficient and more traumatic for the resident. Moreover, transfers should generally not take place on Fridays or holidays because staff at the new facility might not be available to provide a smooth transition.

[I.] [A.] Good discharge planning should include consideration of the proximity of the new home to friends and family, the possibility of moving residents who have strong friendships to the same facility, the possibility of ensuring residents go the facilities in which favorite caregivers will now be employed, and all of the considerations discussed above regarding choosing a facility.

[I.] [A.] All of the state and federal rights residents have regarding involuntary discharges in other situations apply to discharges due to home closings. However, these rights are often ignored when a home closes. Vigorous advocacy is required to ensure that these important rights are not violated. Numerous studies show that vulnerable residents frequently suffer from increased morbidity and mortality when they are transferred to other facilities; state and federal law seek to minimize the trauma residents face in this situation.

[I.] [A.] It appears that the state interagency plan for nursing home closures is utilized much more energetically in involuntary closures than in voluntary closure situations. Often, facilities are left to handle much of the details of the discharges in voluntary closures with little state oversight. This can be detrimental to residents who may be as traumatized by a voluntary closure as an involuntary one; for them, the reality is the same in both situations.

Portions of this outline were drawn from material in Eric M. Carlson's excellent book, *Long Term Care Advocacy*, Lexis Publishing, 2000 and in Chapter 7, *Advising the Elderly Client*, the Institute of Continuing Legal Education, 1998.