Evaluating and Enhancing Federal Responses to Abuse and Neglect in Long-Term Care Facilities

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In 2011, WKYC television in Cleveland, Ohio aired a video of alleged nursing home abuse. A hidden camera captured a nursing assistant throwing a 78-year-old resident with advanced Alzheimer's disease into her bed and wheelchair, slapping her, and pushing her face to the wall. The nursing assistant then covered the resident's face with her gown and mocked her.

Flash back to 1970 when Ralph Nader published *Old Age: The Last Segregation*, a report on conditions in America's nursing homes. It cited a strikingly similar situation to the Cleveland incident in which a nurse "jerked [the resident] out of the chair, shoved her against the bed, and roughly undressed her…[The nurse] told her to shut up…[and] threw the covers over her, covering her face" (Townsend, 1970, p. 56).

These two incidents—similar in nature but over 40 years and hundreds of miles apart—lead us to ask what decades of federal law and policy aimed at protecting vulnerable residents have accomplished and what combination of federal initiatives could more effectively address abuse and neglect in long-term care facilities.

Although this article considers abuse and neglect in all forms of residential care facilities, significantly greater consideration is given to elder mistreatment in nursing homes. This reflects the reality that, to date, both research and federal policy have focused primarily on nursing homes. It does not suggest that there is any less cause for concern about the victimization of elders in other residential care facilities. Indeed, federal attention to abuse and neglect in these settings is long overdue.

The Scope of Mistreatment

Approximately 2.5 million Americans live in nursing homes, assisted living, and adult care facilities. No comprehensive data exist regarding the extent of elder mistreatment in these facilities, but research suggests that it is widespread and perpetrated by facility employees, visitors, and other residents. An early study found that 10 percent of nurses and nursing assistants in nursing homes acknowledged committing at least one act of physical abuse and 40 percent at least one act of psychological abuse during the previous year (Pillemer & Moore, 1989). Moreover, 36 percent said that they had witnessed physical abuse and 81 percent reported observing psychological abuse by staff that year. A decade later, a national prevalence study of theft in nursing homes discovered that one in five residents was victimized (Harris & Benson, 1999). In 2008, research on sexual abuse in facilities found that less than one-fifth of the allegations were substantiated, but 42 percent of confirmed victims were elders (Ramsey-Klawsnik, Teaster, & Mendiondo, 2008). Finally, in a comparison of elder mistreatment by paid caregivers across settings, researchers found nursing homes had higher rates of all types of mistreatment than did either assisted living or home care, even adjusting for patient health conditions (Page, Conner, Prokhorov, Fang, & Post, 2009).

Risk Factors for Mistreatment

The research on risk factors for elder mistreatment in facilities is even more limited than that on prevalence and incidence. However, the literature suggests certain characteristics can increase the likelihood of abuse. Staff who lead stressful lives, have a poor understanding of resident behaviors, or suffer from job burnout and negative attitudes toward residents are at greater risk of becoming abusers. Facilities that are short-staffed, have high turnover, provide inadequate training and supervision, have harsh management practices, and lack commitment to abuse prevention efforts create environments where abuse and neglect can flourish. Finally, socially isolated residents or those with dementia or difficult behaviors have an increased risk of mistreatment.

Early Federal Interest and Activity

Twentieth century public policies propelled the development of nursing homes. These included the Social Security Act of 1935, which increased elders' purchasing power for housing and care, the Hill-Burton Act of 1954 and the Housing Act of 1959, which offered financing for nursing home construction and renovation, and Medicare and Medicaid in 1965, which provided public funding for eligible individuals in need of long term care.

From the mid-1960s through the 1970s, public concern about the state of nursing home care was ignited. Exposes of abuse and neglect fueled public outrage and sparked hearings in the U.S. Senate, reassessment of policies at the Department of Health, Education, and Welfare, and a commitment to action by President Nixon. As a result, Congress passed both Public Law 92-603, an attempt to improve quality and cost reimbursement, and the Medicare and Medicaid Antifraud and Abuse Amendments of 1977, aimed at containing costs by curtailing fraud and abuse. Neither proved very successful.

Sweeping Federal Reform of Nursing Home Regulation

In 1982, the Reagan administration proposed easing the requirements for nursing facilities to participate in Medicare and Medicaid. Advocates and most state regulatory agencies vigorously opposed the changes and sought instead to obtain more stringent regulation and consistent enforcement. In the ensuing furor, Congress commissioned the Institute of Medicine (IOM) to undertake a study that would "serve as a basis for adjusting federal (and state) policies and regulations governing the certification of nursing homes so as to make those policies and regulations as appropriate and effective as possible." (Institute of Medicine, 1986, p. 2)

The landmark 1986 IOM report asserted that many facilities provided inadequate and sometimes shockingly deficient care, violated residents' rights, and subjected residents to abuse and neglect. Moreover, it lamented that the existing regulatory system was incapable of forcing substandard facilities to improve or close. The report argued that stronger federal leadership was essential and that effective regulation could achieve substantial improvements in nursing home quality.

The IOM recommendations and the subsequent work of a coalition of stakeholders organized by the National Citizens Coalition for Nursing Home Reform formed the basis for the passage in 1987 of the Nursing Home Reform Act (OBRA '87). Instead of merely establishing minimum standards, the law articulated the ambitious mandate that facilities "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care" (Nursing Home Reform Act, 1987, (b(4)(A), and (d)(1)(A)). It also included detailed requirements governing almost every aspect of nursing home life and focused on resident outcomes, quality of care, and quality of life. In addition, it required training and competency evaluation of nurse aides and the creation of a registry in each state to identify all certified aides and flag those who had committed abuse, neglect, or misappropriation of resident property.

The law further provided explicit guidance on inspections of and enforcement in facilities. It included a flexible range of intermediate sanctions that could be imposed when facilities failed to meet federal requirements including directed plans of correction, imposition of temporary managers, denials of payment, fines known as civil monetary penalties, and termination.

Nursing home industry objections delayed promulgation of key final regulations until 1995. Nevertheless, the following year, the Commonwealth Fund found the law had sparked substantial improvements in nursing home quality (Hawes, 1996). Most significantly, the use of restraints declined almost 50 percent, freeing 250,000 elderly patients a year (Hawes, 1996). Other progress—including a notable increase in family and resident involvement in care planning, reductions in psychotropic drug utilization, increased use of behavior management programs to address challenging behaviors, and doubling of efforts to reduce incontinence—demonstrated the law was effective in its key goal of improving residents' quality of life.

Despite this encouraging news, study after study has echoed the IOM committee's lament that the regulatory system still fails to force substandard nursing homes to improve or get out of the business. Since 1999, the Government Accountability Office has published reports documenting the need to strengthen oversight of state survey agencies and the failure of the enforcement process to deter some facilities from repeatedly harming residents. The U.S. Senate Special Committee on Aging has held numerous hearings on topics including inadequate staffing and failures in enforcement. In 2011, the Department of Health and Human Services's (HHS) Office of Inspector General (OIG) released a report regarding widespread misuse of psychotropic drugs in nursing facilities.

Federal databases also document the continuing occurrence of abuse and neglect in nursing homes. In

2009, state and federal enforcement data revealed that 16.8 percent of facilities were cited for abuse, improper use of chemical and physical restraints, or staff mistreatment of residents. That year, almost a quarter of facilities received a citation for actual harm or placing residents in immediate jeopardy (Harrington, Carrillo, Blank, & Obrian, 2010).

Much of the inability of federal law to eradicate abuse and neglect rests with the absence of appropriate minimum staffing requirements. In 2001, a 10-year study funded by HHS acknowledged the inescapable link between staffing and quality of care. It concluded that in 2000, "over 91 percent of nursing homes had nurse aide staffing levels below that identified as minimally necessary to provide all the needed care processes that could benefit their specific resident population" (Abt Associates, 2001, p. 6).

The vast majority of facilities across the country continue to have insufficient staff to meet the minimum standard identified in the study. Not surprisingly, ombudsman complaint data reveal that failure to respond to requests for assistance is one of the most common complaints ombudsman staff receive, an obvious consequence of persistent understaffing in facilities.

Current Federal Strategies

Because the full promise of the Nursing Home Reform Act has never been realized and because enforcement in itself cannot assure quality of care and life, the federal government has embarked on other strategies to address abuse and neglect.

Litigation. The federal government has a number of powerful civil and criminal tools in its litigation toolbox. It has used these strategies adroitly not just to punish providers whose facilities are substandard, but also to seek sustained improvements in the lives of the residents of those facilities. Two particularly potent examples are the government's use of the False Claims Act and its exclusion power in both civil and criminal cases.

In egregious failure of care cases, the Department of Justice (DOJ) has sued nursing facilities and other health care providers using an innovative claim pursuant to the False Claims Act. In these cases, DOJ alleges both that the provider presented a claim for reimbursement for services that were so substandard they were essentially worthless or non-existent and that the provider knowingly submitted false certification that it had complied with federal standards.

In the first False Claims Act case in 1996, a resident of a Philadelphia nursing home was admitted to a hospital shortly before his death. He suffered from malnourishment, dehydration, anemia, and severe pain. He also had 26 serious pressure ulcers, including a grapefruit-sized one on his hip that descended to the bone and another one that virtually eviscerated his shoulder. His leg was gangrenous and the toes of one foot were falling off. When the U.S. Attorney's Office investigated the case, it uncovered both neglect of other residents in the same nursing home and similar failures of care in other facilities owned by the same company.

In successful False Claims Act cases, providers can be forced to pay three times the amount of the false claim and substantial fines for *each* instance in which a false billing is submitted—in this case, for each day reimbursement was requested and each service that was billed for each resident who was neglected. Given the magnitude of facilities' financial liability, many providers are willing to make significant concessions to settle the matter. In the case described above, for example, the provider paid $575,000 in damages and agreed to implement in all of its 18 homes a set of protocols developed by experts to address the pervasive neglect identified in the facilities. The provider also agreed to hire an independent monitor to oversee care and to write letters of apology to the families of three neglected residents.

Beginning in 1999, False Claims Act cases were pursued by DOJ against most of the largest nursing home chains in the country, often in the context of bankruptcy proceedings. The settlement in those cases included multi-year Corporate Integrity Agreements (CIAs) overseen by independent monitors. CIAs were designed not just to bring poor care up to minimal standards, but to promote best practices across chains in which patterns of poor care had been repeatedly documented. While preliminary studies found that these agreements result in some improvements, they were never rigorously evaluated, and it is unclear that they assure sustained compliance. Nevertheless, the CIAs do provide a vehicle for compelling chain-wide accountability across hundreds of facilities. This is a significant contrast to the usual enforcement actions that arise from Medicare and Medicaid provider agreements with individual facilities and that prevent regulators from imposing sanctions across multiple facilities owned by the same provider.

In certain circumstances, OIG has statutory authority to exclude individuals and entities that defraud or abuse federal health care programs, a frightening prospect for nursing facilities in an industry in which Medicaid and Medicare reimbursement typically amounts to more than half of all revenues. In 2000, DOJ and OIG entered into a settlement against Beverly Enterprises, the nation's

largest nursing home chain, in which Beverly agreed to pay a $170 million civil settlement and a $5 million criminal fine. In addition, a Beverly subsidiary pled guilty to a felony that required a mandatory exclusion from Medicare and Medicaid. DOJ and OIG crafted an agreement to assure that the subsidiary divested itself of its 10 facilities before the exclusion took effect, thus protecting residents and enabling them to remain in their homes. In addition, Beverly entered into a CIA with OIG.

Enhanced Enforcement Efforts. The Centers for Medicare & Medicaid Services (CMS) has continued to tweak the federal survey and enforcement system. Surveyors now schedule more surveys on nights and weekends to increase the unpredictability of surveys and to identify problems that are more likely to occur when facilities have fewer direct care and administrative staff. State agencies also are permitted to impose civil monetary penalties more promptly.

In addition, each state except Alaska is required to select two or more chronically noncompliant facilities as Special Focus Facilities (SFF). These 136 SFFs across the country are surveyed twice as often as other facilities, subject to more robust enforcement efforts if deficiencies are found, and listed on the CMS website. In a study of the SFF program last year, the GAO noted somewhat inconsistent implementation of the program across the country. Moreover, while the GAO found that most facilities did in fact improve, not all were able to sustain improvements after leaving the program.

Nursing Home Compare. The Nursing Home Compare website is designed to educate the public about nursing home quality and to create incentives for facilities to improve. The site provides detailed and accessible information about every Medicare- or Medicaid-certified facility in the country including summaries of surveys and fire safety inspections and information about staffing and quality measures. In recent years, the website has included a five-star rating system for overall quality and individual star ratings for staffing levels and quality measures. To date, these categories have relied on self-reported data that are not audited. Pursuant to the Patient Protection and Affordable Care Act of 2010, CMS will soon use facility payroll data to provide more reliable staffing information, and the GAO will study the five-star rating system to determine if it can be improved.

The Long-Term Care Ombudsman Program. The Long-Term Care Ombudsman Program was authorized by the Older Americans Act (OAA) in 1978. Ombudsman programs in each state are comprised of a full-time state ombudsman and both paid staff and a significant corps of volunteers. Their mandate includes identifying, investigating, and resolving resident complaints in long-term care facilities and providing information to residents and families. However, they are also required to seek systemic change through legal and administrative advocacy. While ombudsman data reveal that staff investigate and provide information in hundreds of thousands of cases each year regarding nursing homes and other residential care facilities, ombudsman programs, often housed in State Units on Aging, sometimes lack the independence and resources to engage in the broader advocacy the OAA envisions.

Patient Protection and Affordable Care Act of 2010. The Elder Justice Act and the nursing home transparency provisions included in the Patient Protection and Affordable Care Act of 2010 are the first federal provisions since the Nursing Home Reform Act to provide significant tools to address abuse and neglect in long-term care. First, the Act recognizes the vital role both advocacy and regulation play in identifying and responding to abuse and neglect. It authorizes funding to support long-term care ombudsman programs and a national training institute for surveyors, as well as additional grants to states to enhance complaint investigation protocols. Second, because of the critical role of staffing, the Act authorizes funding to enhance efforts to recruit, train, and retain the long-term care workforce. Third, it requires the immediate reporting to law enforcement of crimes against residents in long-term care facilities that receive at least $10,000 per year in federal funds and establishes additional penalties for facilities that retaliate against employees who report violations. Fourth, it provides support for a study regarding the establishment of a national nurse aide registry and authorizes funds for state and national background check programs regarding employees who have direct access to residents. Finally, the new law requires CMS to include additional information for consumers on the Nursing Home Compare website, including reports of crimes committed in facilities, more accurate staffing data, and links to state survey information.

To date, there have been no appropriations for these important provisions. Some provisions can be implemented even in the absence of appropriations, however, and CMS is now enforcing the requirement that crimes in nursing facilities be immediately reported. Prompt action by Congress and the administration to fund and implement the new law is necessary to demonstrate genuine commitment to addressing mistreatment and to generate momentum inside and outside of government.

Federal Initiatives in Other Residential Care Facilities

In the more than four decades since federal funding first paid for nursing home care, the landscape of long-term care has changed dramatically. In the early years, individuals who could no longer remain at home had little choice but to enter nursing homes. By the end of the 20th century, an array of residential care facilities, sometimes called assisted living, adult foster care, board and care, domiciliary care, or personal care facilities, began to emerge as both an option for individuals who did not need nursing-home-level care and as a less expensive and restrictive alternative to nursing homes for those who did. More recently, federal and state attention has shifted to promoting home and community-based care as a popular and cost effective option. More and more long-term care consumers—the same vulnerable population who used to be on the inexorable path from home to nursing home—are now able to choose alternatives to nursing homes or find themselves transitioning among home-based, assisted living, and nursing facility services as their needs and circumstances change. But despite this seismic shift in the long-term care world, federal policy to address abuse and neglect in long-term care has continued to focus almost exclusively on nursing facilities.

Regulation of residential care facilities varies considerably across states, and there is no federal regulation of these facilities. Although significant federal Medicaid funds now flow into assisted living facilities—generally for residents who meet the same level of care requirements as nursing facility residents—the federal government relies on widely diverse state licensure efforts to set quality standards, conduct inspections, and respond to concerns about substandard quality, abuse, and neglect. Thus, while nursing home residents benefit from federal initiatives developed over decades, their counterparts with similar vulnerabilities live in assisted living facilities where none of those safeguards apply.

In 2009, a study funded by the DOJ determined that stronger federal engagement was essential to address abuse and neglect in residential care facilities. It concluded that "[t]he universal lack of resources, the enormous variation across jurisdictions, and the low priority given to elder abuse and neglect make it difficult to see how significant progress can be made without some federal standards and financial support for investigating, detecting, resolving, and preventing elder abuse in residential care" (Hawes & Kimbell, 2009, p. i).

Recently, there has been evidence of limited and belated federal attention to residential care facilities. For example, in 2011, CMS published a Notice of Proposed Rulemaking delineating the characteristics required for residential care facilities to qualify as Medicaid-funded home and community-based services settings. The proposed rule included requirements about the physical space as well as provisions regarding residents' rights and person-centered care. Also, in March, 2011, the U.S. Senate Special Committee on Aging convened an Assisted Living Roundtable that considered both state efforts and the limited federal engagement in this issue. Nevertheless, these developments are only tiny steps along the road to necessary federal protections for elders living in residential care facilities.

Recommendations

1. Mandate Staffing Ratios and Additional Staff Training in Nursing Facilities. No element is more basic to preventing abuse and neglect than assuring that an appropriate number of well-trained staff members are on duty in the facility. But just having enough staff who could theoretically perform all necessary tasks is not sufficient. Since residents present complex and varied medical conditions and frequent behavioral challenges, nursing assistants will need more than the federal minimum requirement of an initial 75 hours of training. Moreover, staff must treat residents with respect and dignity; these positive interactions are not necessarily instinctive but must be learned and reinforced.

The good news is that we now better understand the minimum levels of staffing necessary to prevent harm. Our next step must be to require that all nursing facilities meet that standard and that direct care staff receive appropriate training and support.

2. Continue to Support OBRA '87. Since 1987, there have been repeated efforts by the nursing home industry to repeal or weaken the Nursing Home Reform Act. However, the Act's detailed vision of quality remains just as apt now as when it was first enacted. Federal policymakers must strive to realize the full promise of the law by increasing support for state survey agencies and continuing to revise survey and enforcement protocols.

3. Collect Basic Data About and Establish Minimum Standards for Residential Care Facilities. We know that extremely vulnerable elders live in residential care facilities other than nursing homes and we suspect they are the frequent victims of abuse and neglect. Significant federal attention and research is required to better understand the needs of this population. In the meantime, we should establish basic requirements, at least for facilities that receive Medicaid funding, including mandates for staff training, resident assessments, care planning, and residents' rights.

4. Fully Fund and Implement the Provisions of the Elder Justice and Nursing Home Transparency Provisions of the Patient Protection and Affordable Care Act. The passage of the Elder Justice Act and the nursing home transparency provisions of the Affordable Care Act were the culmination of years of advocacy and analysis of the most critical missing pieces in addressing elder abuse and neglect. Still, in the more than a year since the passage of the law, no funds have been appropriated to realize these long overdue initiatives. It is time for Congress to act to assure funding for and implementation of these important provisions.

5. Tolerate Less, Expect More. In the world of residential care facilities, elders are in many ways victims of our own low expectations. We accept that residents frequently live in small, impersonal rooms with strangers who are ill, disruptive, and sometimes violent; that they are bathed only once or twice a week; that many facilities lack air conditioning so that both staff and residents swelter in extreme heat; and that staff cannot respond to all the needs residents present. In short, we accept for our most vulnerable elders a host of conditions that we would never tolerate in our own lives. And while not all these conditions rise to the level of abuse and neglect, they create a slippery slope in which our concern about the indignities and suffering elders experience is diminished. By simply expecting and demanding more, we will take an important step to creating real quality in the lives of residents. Vulnerable elders deserve no less.

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References

Abt Associates. (2001). *Appropriateness of minimum nurse staffing ratios in nursing homes* [Report to Congress] Prepared for the Centers for Medicare and Medicaid Services. Retrieved October 11, 2011, from http://www.allhealth.org/briefingmaterials/abt-nursestaffingratios%2812-01%29-999.pdf

Harrington, C., Carrillo, H., Blank, B., & O'Brian, T. (2010). *Nursing facilities, staffing, residents and facility deficiencies, 2004 through 2009.* San Francisco: University of California.

Harris, D. K., & Benson, M. L. (1999). Theft in nursing homes: An overlooked form of elder abuse. *Journal of Elder Abuse & Neglect*, *11*(3), 73-90.

Hawes, C. (1996). *Assuring nursing home quality: The history and impact of federal standards.* New York: Commonwealth Fund Policy Monograph. Retrieved August 1, 2011, from *http://mobile.commonwealthfund.org/Content/Publications/Fund-Reports/1996/Dec/Assuring-Nursing-Home-Quality—The-History-and-Impact-of-Federal-Standards-in-OBRA-87.aspx*

Hawes, C., & Kimbell, A. (2009). *Detecting, addressing and preventing elder abuse in residential care facilities*. Washington, DC: National Institute of Justice.

Institute of Medicine. (1986). *Improving the quality of care in nursing homes.* Committee on Nursing Home Regulation.

Nursing Home Reform Act. (1987). 42 U.S.C1396r, 42 U.S.C. 1395i-3.

Page, C., Conner, T., Prokhorov, A., Fang, Y., & Post, L. (2009). The effect of care setting on elder abuse: Results from a Michigan survey. *Journal of Elder Abuse & Neglect*, *21*, 239-252.

Pillemer, K., & Moore, D. W. (1989). Abuse of patients in nursing homes: Findings from a survey of staff. *The Gerontologist*, *29*(3), 314-320.

Ramsey-Klawsnik, H., Teaster, P., & Mendiondo, M. (2003). Researching clinical practice: Findings from the study of sexual abuse in care facilities. *Victimization of the Elderly and Disabled*, *11*, 17-18, 24, 28, 31.

Townsend, C. (1970). *Old age: The last segregation.* New York: Grossman Publishers.