Siege Mentality: How the Defensive Attitude of the Long-Term Care Industry Is Perpetuating Poor Care and an Even Poorer Public Image

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I. INTRODUCTION

Although each day nursing facilities care for approximately 1.5 million vulnerable elderly individuals, the nursing facility industry is bedeviled by an abysmal public image. To explain this poor public image, resident advocates point to the industry’s substandard performance over the years, but the industry sees itself as a scapegoat. The divergence between these two views—with nursing facilities
as either victimizers or victims—has led to schizophrenic public policy. The relationship between government and nursing facilities is based nominally on an "enforcement-first" structure but, as a practical matter, loopholes within the enforcement system have crippled enforcement for all but the most egregious and longstanding facility violations. Meanwhile, nursing facility representatives are attempting, on numerous fronts and through a variety of stratagems, to divert governmental agencies further away from enforcement and towards a less adversarial, more consultative role.

II. BAD PRESS AND BAD FEELINGS: NURSING FACILITIES AS SOCIETAL PARI AH S

Nursing facilities occupy a truly unique place in American society and in the American psyche. But “unique,” in this context, is hardly a compliment.

Despite the fact that each day nursing facilities provide life-sustaining nursing care for approximately 1.5 million vulnerable residents—more personally, for ourselves, our spouses, and our parents—the public image of nursing facilities is hardly benevolent. Like the haunted mansion in a "B" movie, the nursing facility is foreboding and a bit mysterious; although one occasionally notices the nursing facilities around town, she has no desire to enter—until an illness to her or a family member leaves no alternative.

The “unique” status of nursing facilities results from facilities being alternately ignored and reviled. The few newspaper stories concerning nursing facilities generally convey disturbing images: a female resident being raped by a young, mentally-ill resident, an Arizona resident burning to death after being left in the sun for seven hours, a resident dying soon after being found in a bed covered with ants, a California resident having her arm pulled out of its socket by nurses, or a Michigan resident strangling to death, caught between her mattress and bed rails.

Even less drastic events are given a similarly nightmarish presentation. Representative of such presentation is this lead paragraph from a Los Angeles Times article, concerning a report on California nursing facilities issued by the General

1. Consistent with federal law, this article uses the term “nursing facility” to denominate those facilities that in the vernacular are commonly referred to as “nursing homes” or “convalescent hospitals.” See 42 U.S.C.A. §§ 1395s-3(a), 1396r(a) (West Supp. 1999) (definitions); 42 C.F.R. § 483.5 (West 2000) (same).


Accounting Office: "The halls reek of urine. Old people lie helpless in their beds hour after hour, soiled diapers unchanged." In a similar vein, television news-magazines often use black-and-white footage from hidden cameras to portray nursing facilities as medical holding pens.

Behind the horror stories is the perception that nursing facility operators are disreputable in some way. For example, when the casino owned by the greedy and malicious Mr. Burns is closed on an episode of television's The Simpsons, his casino employees—"cardsharps, bottom dealers and shills"—are transferred into managerial positions in his nursing facility chain.

III. VICTIMIZERS OR VICTIMS?

What can explain the antipathy and contempt that the news media and popular culture have for an institution that cares for sick, elderly individuals? This question's two divergent answers—each answer 180 degrees from the other—lead to two entirely different philosophies for the repair of a care delivery system that, by all accounts, is broken.

From the point of view held generally by resident advocates and governmental agencies, nursing facilities have earned their societal opprobrium by providing a consistently abysmal quality of care. The necessary response? In the vernacular, "throw the book" at the many substandard facilities. More precisely, legal requirements must be refined, and enforcement of the law must be strengthened.

9. Mr. Burns: I'm just thinking of my employees. All the cardsharps, bottom dealers and shills. Where will they go?
Mr. Smithers: They're managing your chain of nursing homes, sir.
Mr. Burns: Excellent!
The Simpsons: Viva Ned Flanders (Fox television broadcast, Jan. 10, 1999).
10. For the purposes of this article, resident advocates are individuals who work on a paid or unpaid basis to uphold the rights of the residents of long-term care facilities. Many resident advocates and advocacy organizations belong to the National Citizen's Coalition for Nursing Home Reform, located in Washington D.C.
11. Federal and state agencies are responsible for surveying nursing facilities, and for enforcing the relevant law against these facilities. See, e.g., ERIC M. CARLSON, LONG-TERM CARE ADVOCACY § 2.26 (1999) (discussing enforcement of federal nursing facility law by the federal Health Care Financing Administration and state survey agencies).
Nursing facilities,¹⁴ and especially their trade associations,¹⁵ have an entirely different perspective, as if facility representatives and resident advocates lived on two separate planets. Facility representatives see themselves as scapegoats for families and a society that have turned their backs on sick elders.¹⁶ The facilities are victims, not victimizers, and feel aggrieved with an intensity that is no less than that held by those who advocate on behalf of injured residents.

Specifically, from the facilities' point of view, the "facility as a victim" is subjected to an intense and punitive level of regulation. For example, in response to a scathing General Accounting Office report finding that thirty percent of California nursing facilities had caused death or serious physical harm to residents,¹⁷ facility representatives claimed in an editorial that "California's nursing home industry is one of the most highly regulated, and its enforcement system is probably the most effective in the country."¹⁸ More generally, various facility representatives regularly claim—without attribution—that the nursing facility industry is second in regulatory oversight only to the nuclear power industry.¹⁹

IV. THE CURRENT FEDERAL ENFORCEMENT SYSTEM

In 1983, Congress commissioned the Institute of Medicine to study the condition of the nation's nursing facilities, and to recommend improvements to the federal regulatory system.²⁰ The resultant report, entitled Improving the Quality of Care in Nursing Homes,²¹ was published in 1986, and led to the enactment of the federal Nursing Home Reform Law, part of the Omnibus Budget Reconciliation Act of 1987.²²

170, 203-212.

14. See supra, note 1 (defining nursing facilities for the purposes of this article).
15. Nursing facility trade associations lobby legislators and governmental agencies on behalf of their member facilities. Hereinafter this article uses the term "facility representatives" to refer jointly to nursing facilities and nursing facility trade associations.
16. See, e.g., Richard Wolfe & Jonathon E. Cohn, Keeping Nursing Homes Healthy: The Elder-Care Problem Won't Be Solved By Politics and More Rhetoric, L.A. DAILY J., August 19, 1998 (alleging that "[m]any of the complaints that are made [against facilities] have more to do with addressing the guilty conscience of a child or other loved one than with a bona fide care issue"); John O'Connor, Use Dollars and Sense to Fix Facilities, McKNIGHT'S LONG-TERM CARE NEWS, Sept. 1998, at 89 (explaining that poor care is a result of allegedly inadequate Medicare and Medicaid reimbursement rates); Rosenblatt & Marquis, supra note 8, at A1 (reporting that nursing facility representatives dismiss GAO report as "political scapegoating").
18. Wolfe & Cohn, supra note 16.
19. The author has read and heard this claim numerous times, most recently on August 27, 1999 by former nursing facility administrator Abraham Lutfi, during an AARP forum in Baldwin Park, California.
20. See, e.g., IOM REPORT, supra note 12, at 248.
21. Id.
22. See 56 Fed. Reg. 48826 (1991) (Institute of Medicine report the genesis of the Nursing Home Reform Law). The Nursing Home Reform Law is described more accurately (but more cumbersomely) as the 1987 Nursing Facility Amendments to the Medicare and Medicaid Acts. The Nursing Home Reform Law is codified

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Consistent with the recommendations of the Institute of Medicine, the Nursing Home Reform Law focuses on the issue of whether residents receive adequate individualized care. The standard is set high: under the Reform Law and accompanying regulations, each resident must receive the care that she needs to "attain or maintain the highest practicable physical, mental, and psychosocial well-being." Furthermore, this standard applies to virtually every aspect of care that might be needed by a nursing facility resident: for example, rehabilitation services, activity programs, and the prevention and treatment of bed sores.

The government versus industry battles during the 1990's have largely been fought over the enforcement of the Nursing Home Reform Law. Furthermore, due to the political power of the nursing facility trade associations, the industry has won the majority of the significant battles, saddling enforcement agencies with a loophole-ridden system.

The weakness of the current enforcement system raises queasy feelings of déjà vu for any resident advocate. In its 1986 report, the Institute of Medicine criticized the lenient nature of the then-existing enforcement system. The Institute noted that "federal procedures for dealing with facilities found to be out of compliance were oriented toward helping facilities to improve rather than enforcing the certification standards." Facilities generally were "not punished for violations directly, but rather for failing to carry out an administrative order to correct violations by a certain date." As a result, too many facilities remained out of compliance for months or years, coming into compliance sporadically, only when necessary to renew eligibility for continued Medicare and Medicaid reimbursement.

Unfortunately, the current enforcement system resembles in many ways the system criticized by the Institute of Medicine in the 1980's. This is due primarily to the pressure imposed on the Health Care Financing Administration (HCFA) by the nursing facility trade associations. This pressure has caused HCFA to insert

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at 42 U.S.C.A. § 1395i-3 (West Supp. 1999) (applicable to any resident of a nursing facility certified to accept Medicare reimbursement) and 42 U.S.C.A. § 1396r (West Supp. 1999) (applicable to any resident of a nursing facility certified to accept Medicaid reimbursement). Sections 1395i-3 and 1396r are virtual mirror images of each other.


24. See, e.g., CARLSON, supra note 11, §§ 2.02, 2.07-2.21 (1999) (providing the required level of nursing facility services under federal law).


27. 42 C.F.R. § 483.25(e).


29. Id. at 147.

30. Id. at 148.

31. Id. at 147.
significant loopholes in the enforcement procedures set forth in the Code of Federal Regulations and the HCFA State Operations Manual.\(^{32}\)

For example, a government survey agency generally does not assess a remedy for a violation unless the offending nursing facility first has had an opportunity to correct the violation by a date set by the agency.\(^{33}\) This grace period—eerily reminiscent of practices condemned by the Institute of Medicine—is mentioned nowhere in either statute or regulation, and represents a significant give-away by HCFA during the drafting of the State Operations Manual.\(^{34}\)

In practice the opportunity to correct violations often means that a remedy cannot be assessed. This occurs for at least two reasons. First, many and possibly most violations are one-time occurrences that cannot truly be “corrected.” If, for example, a resident develops a bedsore after his skin condition is not monitored properly, neither the improper conduct nor the injury can be reversed. What passes for “correction” in such an instance is the submission by the facility of a “plan of correction,” which in practice is little more than the facility’s written promise that it will not commit a similar violation in the future.\(^{35}\)

Second, many survey agencies do not have enough personnel to verify that a correction has or has not taken place. Indeed, pursuant to a 1995 HCFA Memorandum, survey agencies for the time being are not required to verify a facility’s claimed correction if the violation’s severity has been classified as no greater than “no actual harm with potential for more than minimal harm that is not immediate jeopardy.”\(^{36}\) As a result, a remedy is unlikely to be assessed whenever a facility claims that “correction” has occurred by the “date certain.”

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33. HCFA STATE OPERATIONS MANUAL §§ 7304(A),(B), 7313(B) (1999) [hereinafter HCFA MANUAL].

34. See NSCLC LETTER, supra note 32, at 20.

35. Actually, the HCFA Manual requires that a “plan of correction” explain how the particular resident’s condition will be corrected, how the facility will identify other at-risk residents, what systemic changes will occur, and how the facility will monitor corrective actions. HCFA MANUAL, supra note 33, § 7304(C). These standards, however, generally are not followed in practice. Most plans of correction explain that the facility will act appropriately in the future, and then list the facility employee who supposedly will monitor the situation. For example, in the bedsore scenario sketched in the text, the plan of correction might state that all residents in the future will receive adequate attention to their skin condition, and that the director of nursing will be responsible for monitoring the facility’s performance.

36. Memorandum from HCFA Deputy Bureau Director for Survey and Certification to Regional Administrators and State Agency Directors, Interim Revisit Policy (Dec. 6, 1995) (on file with the McGeorge Law Review); HCFA MANUAL, supra note 33, § 7400(E)(1). The HCFA Memorandum states that revisits are not required for violations classified in “Boxes D, E or F”; section 7400(E)(1) explains that those boxes correspond to violations classified as “no actual harm with potential for more than minimal harm that is not immediate jeopardy.”
The General Accounting Office (GAO) addressed the grace period issue, along with other issues, in a 1998 report focusing on California nursing facilities. The GAO report noted that facilities were given grace periods almost universally, with only two narrow exceptions. First, grace periods were not allowed in situations in which a violation had placed a resident's health or safety in "immediate jeopardy." Second, grace periods also were not allowed if the facility had been classified as a "poor performer," which at that time was defined as a facility "with a history of going in and out of compliance and/or a facility that has no system in place to monitor its own compliance."

In response to the GAO report, President Clinton announced that survey agencies henceforth would be instructed to "[e]nsure that nursing homes are in compliance with standards before lifting sanctions." President Clinton also authorized HCFA to "direct enforcement authorities to impose civil monetary penalties immediately upon finding that a nursing home has committed a serious or chronic violation." The President noted that, prior to these changes, "enforcement officials often [had] give[n] nursing homes numerous opportunities to come into compliance, rather than imposing immediate sanctions."

Despite these presidential orders, a survey agency rarely assesses a remedy without first granting the facility a grace period. First, although HCFA promulgated regulations authorizing assessment of a civil monetary penalty for only one violation, the validity of these regulations is in doubt.

Second, in regard to the other remedies used by survey agencies, a remedy generally is not imposed until a facility is given an opportunity to "correct" the violation. The opportunity to correct is unavailable only if the facility's violation

38. HCFA Manual, supra note 33, § 7313.
39. Id. § 7304(B).
40. Id.
41. Actually, the President's announcement was made the week prior to the release of the GAO report, in an effort to preempt criticism. See Robert Pear, Clinton Announces Drive to Cut Abuse At Nursing Homes, N.Y. Times, July 21, 1998, at A1; Robert A. Rosenblatt, Clinton Seeks Improved Nursing Home Oversight, L.A. Times, July 22, 1998, at A1; Rosenblatt & Marquis, supra note 8, at A1.
43. Id.
44. Id.
46. See Complaint, American Health Care Ass'n v. Shalala, No. 1:99 CVO 127 (D.D.C. May 18, 1999) (visited Feb. 13, 2000) <http://www.ahca.org/brief/cmpcomplaint.htm>. The lawsuit alleged, among other things, that the relevant provisions of the Medicare and Medicaid Acts do not authorize the assessment of per-violation monetary penalties, and the promulgation of the regulations did not comply with the notice and comment requirements of the federal Administrative Procedure Act. The lawsuit was dismissed on March 7, 2000, for AHCA's failure to exhaust administrative remedies, but the issues raised can be asserted as defenses by individual nursing facilities.
puts residents' health or safety in immediate jeopardy, or if for two consecutive surveys the facility has committed a violation of a severity found to be either "actual harm" or "immediate jeopardy." Although, in all other instances, the survey agency possesses the discretion to allow or not allow an opportunity to correct, most survey agencies continue to give facilities that opportunity. 

For these reasons, the federal enforcement system has been unable to compel substandard facilities to make real improvements. For example, among a sample of seventy-four substandard facilities that supposedly had "corrected" sanctionable violations, sixty-nine of those facilities committed subsequent violations. Because sanctions rarely were imposed, some facilities went through this "yo-yo pattern of compliance and noncompliance" as many as six or seven times. In short, as summarized by the GAO, "[t]he threat of sanctions appeared to have little effect on deterring [facilities] from falling out of compliance again because [facilities] could continue to avoid the sanctions' effect as long as they kept correcting their deficiencies."

V. EFFORTS BY THE LONG-TERM CARE INDUSTRY TO REPLACE OR TRANSFORM THE EXISTING ENFORCEMENT SYSTEM

Both resident advocates and facility representatives are wholly dissatisfied with the enforcement status quo, but for reasons that are consistent with the disparate perspectives discussed above. Resident advocates believe that the enforcement systems at both the federal and state levels have been made impotent by procedural roadblocks and a lack of resources. The solution at either level—state or federal—would be the elimination of roadblocks and the addition of resources.
federal—is a streamlining of enforcement processes and an increase in available resources.\footnote{33}

The arguments made by nursing facility representatives assume a dramatically different reality: the problem is too much enforcement and not enough money. The editor of one provider magazine states: “poor-performing facilities are largely the result of flawed oversight and reimbursement systems.”\footnote{34} Similarly, the executive vice president of the American Health Care Association stated that “[e]nforcement activity alone is not the answer; in fact, a single-minded emphasis on enforcement will ultimately hurt quality.”\footnote{35} From this point of view, monetary penalties simply “take money out of the system that should be spent on patient care.”\footnote{36}

According to facility representatives, enforcement can diminish the quality of care by focusing on matters essentially unrelated to resident’s well-being. In the words of a vice president of a nursing facility chain, “the survey system does not measure quality.”\footnote{37} At best, enforcement activities are only beneficial in regards to those few facilities characterized as “bad apples.”\footnote{38}

In general, facility representatives argue that the government should improve care not by regulation and enforcement, but by increasing Medicaid and Medicare rates, and providing “technical assistance” regarding the best ways to provide nursing facility care.\footnote{39} In general, facility representatives advocate a “partnership”

\footnote{33. See, e.g., NSCLC LETTER, supra note 32, at 1, 46 (need for stronger enforcement of federal nursing facility law); McKnight Providers, supra note 52, at 16 (Urban Institute researcher supporting stronger enforcement); CALIFORNIA ADVOCATES FOR NURSING HOME REFORM, STATUS REPORT ON CALIFORNIA’S NURSING HOME INDUSTRY (1998) (demonstrating the need for stronger enforcement of state nursing facility law); PENNSYLVANIA AUDITOR GENERAL, THE OVERSIGHT OF NURSING HOME CARE: RESIDENTS IN JEOPARDY, ch. VIII (1998) (same); WISCONSIN LEGISLATIVE AUDIT BUREAU, AN EVALUATION: NURSING HOME REGULATION, Report 98-2 (1998) (same).

34. O’Connor, supra note 16, at 89 (emphasis added).

35. McKnight Providers, supra note 52, at 16; see also Rosenblatt, supra note 41, at A22 (reporting a similar quote from the same individual).

36. Lisa Werner Carr, Providers Brace for Citation Frenzy As Crackdown Begins, MCKNIGHT’S LONG-TERM CARE, Oct. 1998, at 14 (quoting the president of an Ohio trade association for non-profit nursing facilities); see also CALIFORNIA ASSOCIATION OF HEALTH FACILITIES, HELP US HELP THEM, 5 (1999) [hereinafter CAHF HELP] (“financial penalties alone merely drain resources from resident care”).


38. See McKnight Providers, supra note 52, at 16, 24; see, e.g., Clarke, supra note 57, at 20-21 (vice president of Beverly Enterprises nursing facility chain arguing that “survey system does not measure quality”); Wolfe & Cohn, supra note 16 (editorial by facility representatives, acknowledging existence of “poor performers” but arguing that improved enforcement is less important than increased funding and adjustment of licensure categories).

39. See O’Connor, supra note 16, at 89; see, e.g., CAHF HELP, supra note 56 (brochure developed by California trade association to support legislative advocacy; arguing that state survey agency should focus less on enforcement and more on “quality measurements,” “performance measures,” and prevention); Wolfe & Cohn, supra note 16 (editorial by facility representatives, supporting expansion of state “best practices” program).
between facilities and government.\textsuperscript{60} For example, the executive vice president of the American Health Care Association recommended that government agencies “should work in cooperation with the industry and put the ‘emphasis on the 90% of the people who want to do a good job.’”\textsuperscript{61} A vice president of the California Association of Health Care Facilities advocated for a relationship in which the government survey agency would counsel poorly-performing facilities, and encourage and support good facilities:

We need a system that targets enforcement efforts on facilities with consistent problems and helps them improve the internal systems necessary to ensure continuous quality. We need an enforcement system that supports good providers and shares their successful programs with others, so that all residents can benefit from their example.\textsuperscript{62}

A spokesperson for a national nursing facility chain argued both that the survey process is counterproductive and that government should act cooperatively:

Imposing additional fines will do nothing to evolve the system to where it needs to be, which is a regulatory system that encourages good behavior rather than continuing to come up with ways to beat up the industry. . . . We still are operating under a system that seeks and finds problems where sometimes they don’t even exist.\textsuperscript{63}

A. Government as a Consultant

In various ways, nursing facility trade associations have tried to re-engineer the enforcement system into a cooperative or consultative relationship with the relevant government agency. In the most fully developed example of these efforts, the American Health Care Association worked with the state of South Dakota to develop “an alternative survey process for nursing facilities,” which in December 1996 was submitted by South Dakota to the federal Health Care Financing Administration (HCFA) for approval.\textsuperscript{64}

\begin{flushright}
\textsuperscript{60} McKnight Providers, supra note 52, at 16 (quote from American Health Care Association spokesperson).
\textsuperscript{61} Rosenblatt, supra note 41, at A15.
\textsuperscript{62} Tracy A. Blankenheim, GAO Report Details Abuses, Helps Fuel LTC Crackdown, McKnight’s Long-Term Care News, Sept. 1998, at 26, 27.
\textsuperscript{63} Fine Tuning, CONTEMP. LONG TERM CARE, May 1999, at 12, 14 (statement of spokesperson for Beverly Enterprises).
\textsuperscript{64} Letter from Joan Bachman, Administrator of the Office of Health Care Facilities Licensure and Certification, South Dakota Dept. of Health, to Steven Clauser, Director of Health Care Financing Administration’s Office of Beneficiary Program Research and Demonstration (Apr. 14, 1997) (notes attached to letter); see 62 Fed. Reg. 15187, 15190 (1997); Abt Associates, Evaluation of Private Accreditation of
The "South Dakota Quality Initiative" (SDQI) provided for replacement of the existing enforcement system with "a new system for quality measurement and improvement for nursing facilities." In general, regular surveying would be replaced by a system in which specific surveyors would be assigned to perhaps ten nursing facilities, and would work with those facilities' quality assurance teams on a regular basis. The surveyors' evaluation of the facility would be based in large part on quality indicator data and customer satisfaction surveys.

Government representatives and resident advocacy groups raised numerous objections to the SDQI. Most significantly, under the SDQI enforcement of existing federal standards would disappear or at least diminish. Specifically, South Dakota first proposed that a facility's quarterly Quality Assurance Report could replace government-issued inspection reports. After objections were raised, South Dakota agreed that deficiencies would be recorded on the same form routinely used by survey agencies, but simultaneously suggested that the statement of deficiencies would be written jointly by the government surveyors and the facilities' quality assurance teams.

In any case, participation by government surveyors in a facility's quality assurance activities could compromise any ongoing enforcement. First, a surveyor understandably would find it difficult to cite a facility for which she essentially had been working as a consultant. Second, time and resources dedicated to quality assurance necessarily must limit the effort which government survey agencies can devote to enforcement.

Ultimately, the HCFA refused to grant South Dakota the waiver necessary to operate the SDQI. The HCFA explained that it would "not conduct any demonstration or authorize any waiver of regulation which alters, in any way, the survey, certification or enforcement process as described by both the [HCFA] State

NURSING HOMES, REGULATORY INCENTIVES AND NON-REGULATORY INITIATIVES, AND EFFECTIVENESS OF SURVEY AND CERTIFICATION SYSTEM § 13.6.4.1 (1998) [hereinafter ABT ASSOCIATES] (AHCA working with South Dakota); Toby S. Edleman, HCFA Retreats From Regulatory Role, in NURSING HOME LAW LETTER (National Senior Citizens Law Center), Nov. 7, 1997, at 5 (same).

66. A "quality indicator" is a statistic that may indicate the quality of care provided by a facility. For example, a facility with a high percentage of bed sores or urinary catheters likely is not providing good care. See, for example, the Center for Health Systems Research and Analysis, University of Wisconsin, Nursing Facility Quality Indicator Definitions (1997). Information from the CHSRA is available on the Internet at <www.chsra.wisc.edu>.
67. ABT ASSOCIATES, supra note 64, § 13.6.4.1; see also Edelman, supra note 64, at 4 (questionable validity of customer satisfaction surveys in nursing facilities).
68. ABT ASSOCIATES, supra note 64, § 13.6.4.1; see also CARLSON, supra note 11, § 2.26[2] (statement of deficiencies under federal law).
69. ABT ASSOCIATES, supra note 64, § 13.6.4.1.
70. Certain provisions of federal Medicaid law can be waived by HCFA. These waivers commonly are termed "Section 1115" waivers, because they are authorized by section 1115 of the Social Security Act (42 U.S.C.A. § 1315).
Operations Manual and pertinent regulation.” Nonetheless, the HCFA declared itself “eager to work with the State in the development of special studies and experiments which could be conducted concurrently with the existing survey and enforcement system.” The HCFA specifically indicated that it was exploring parameters for studies involving quality indicators and customer satisfaction surveys, with the ultimate goal of augmenting the enforcement process and providing information to individual nursing facilities.

Recently, the HCFA began integrating use of quality indicators in the existing enforcement system. In addition, the HCFA has taken steps to disseminate information on recommended facility practices, most notably through a “Sharing Innovations in Quality” posting on the Internet.

Regardless of these HCFA actions, nursing facility trade associations have not lessened their calls for an even more “cooperative” relationship with government enforcement agencies. For example, the 1999 legislative platform of the California Association of Health Facilities (CAHF) repeated in many ways the proposals of the SDQI: use of “quality measurements” and customer satisfaction surveys, and a focus on “prevention” rather than “punishment.” The CAHF at one point was able to insert this language into 1999 nursing home reform legislation sponsored by resident advocates, although the resident advocates were able to delete or moderate the CAHF-sponsored language in the version of the legislation that eventually passed the California Legislature.

B. Private Accreditation as a Substitute for Federal Enforcement

In another effort to alter the current model of federal oversight, in 1996 nursing facility representatives arranged for a requirement that the Health Care Financing Administration conduct “a study concerning the effectiveness and appropriateness of the current mechanisms for surveying and certifying skilled nursing facilities for compliance with the conditions and requirements of [federal law].” Most significantly, the study was required to include “a specific framework, where appropriate, for implementing a process under which facilities... may be deemed to meet applicable [M]edicare conditions and requirements if they are accredited

71. Letter from Bruce C. Vladeck, HCFA Administrator, to Joan Bachman, Administrator of the Office of Health Care Facilities Licensure and Certification, South Dakota Dept. of Health (June 20, 1997) (on file with the McGeorge Law Review).
72. Id.
73. Id.
75. CAHF Help, supra note 56, at 5.
76. AB 1160 (Cal. 1999) (as amended on Aug. 17, 1999, but not enacted).
77. AB 1160 (Cal. 1999) (as amended on Sept. 2, 1999, but not enacted).
by a national accreditation body.\textsuperscript{79} In other words, HCFA was mandated to
consider the virtual replacement of the federal inspection and certification process
with the inspection by a private entity such as the Joint Commission on
Accreditation of Healthcare Organizations.\textsuperscript{80}

Ultimately, the push for private accreditation foundered in July 1998 upon the
release of the Congressionally-mandated study.\textsuperscript{81} The study noted that private
accreditation of hospitals has been accepted as a substitute for government
inspection since 1965,\textsuperscript{82} but found that similar “deemed” status for nursing facilities
would not necessarily provide residents with adequate protection, in part because
nursing facility residents are relatively “more vulnerable, dependent and mentally
compromised.”\textsuperscript{83}

The study noted that the nursing facility standards of the Joint Commission on
Accreditation of Healthcare Organizations (JCAHO) are, in several respects, more
abstract than, and inferior to, the standards set by existing federal law. In general,
the JCAHO standards focus more on facility process than on resident outcomes.\textsuperscript{84}
Unlike some of the federal standards, the JCAHO standards do not use specific
numbers (primarily temperatures and weights) to judge a facility’s compliance or
noncompliance.\textsuperscript{85} In addition, the JCAHO standards place less emphasis on resident
rights: whereas the federal standards protect a resident’s decision-making authority,
JCAHO’s resident rights focus on the facility’s level of performance, \textit{e.g.}, a right
to considerate care.\textsuperscript{86}

The study also found that the JCAHO survey process (as opposed to the
substantive standards) is inferior to the HCFA survey process in certain aspects.
Most significantly, JCAHO surveyors may pay relatively little attention to the care
actually provided to residents, whereas the federal survey process calls for
surveyors to spend a significant portion of time both observing care provided to
residents and interviewing residents regarding the care provided.\textsuperscript{87} A JCAHO
survey uses interviews with staff members as the primary means of gathering
information,\textsuperscript{88} consistent with the JCAHO philosophy that the facility is the

\begin{footnotes}
\textsuperscript{80} Similarly, the California Association of Health Facilities in 1997 sponsored legislation that would have
required the State of California to test on a limited basis the replacement of the existing enforcement system with
\textsuperscript{81} See \textsc{generally ABT ASSOCIATES, supra note 64; Pear, supra note 41}.
\textsuperscript{82} \textsc{ABT ASSOCIATES, supra note 64, § 3.2; see 42 U.S.C.A. § 1395bb (West Supp. 1999)}.
\textsuperscript{83} \textsc{ABT ASSOCIATES, supra note 64, § 2.7.1}.
\textsuperscript{84} \textsc{Id. §§ 5.4.1, 5.5}.
\textsuperscript{85} \textsc{Id. § 5.5}.
\textsuperscript{86} \textsc{Id. §§ 5.4.3.1, 5.5}.
\textsuperscript{87} \textsc{Id. §§ 7.2.1.3, 7.3}.
\textsuperscript{88} \textsc{Id. §§ 7.2.1.1, 7.2.2}.
\end{footnotes}
customer. By contrast, a HCFA survey tends to evaluate a facility based on residents' well-being, consistent with a philosophy of the resident as the customer.

The differences between JCAHO surveys and HCFA surveys manifested themselves in varying survey results. In forty-six percent of the sampled facilities (each of which received both a JCAHO survey and a HCFA survey), the JCAHO survey missed violations that were found by the HCFA survey to create a non-isolated potential for more than minimal harm. Furthermore, in seven percent of the sampled facilities, the JCAHO survey missed violations that, in the eyes of the HCFA survey, caused harm to residents. In two instances, the JCAHO survey awarded an Accreditation with Commendation, a recognition of supposedly excellent care, to a facility found by the HCFA to be harm-causing.

For these reasons and others, the HCFA announced, concurrent with the release of the study, that it would "not allow private accreditation agencies to substitute for state reviews of nursing facilities." As Health and Human Services Secretary Donna Shalala put it, "[The private accreditation agencies] miss too much." This announcement halted the push by nursing facility representatives for deemed status on the federal level.

C. Assisted Living

1. A More Favorable Image

In perhaps the purest example of the long-term care industry's push for regulatory flexibility or leniency, long-term care providers have introduced an "assisted living" model in which the relationship between a residential care facility and a resident is determined primarily through contract. In the abstract, the assisted living model allows the facility to provide carefully individualized care to its residents. However, this model also releases facilities from government oversight to a certain extent.

89. Id. § 7.3.
90. Id. § 7.3.
91. Id. §§ 8.4.2.2.2, 8.4.2.2.3, 8.5.3.
92. Id. §§ 8.4.2.2.4, 8.5.3.
93. Id. § 8.5.3.
94. Pear, supra note 41, at A14 (statement of Donna Shalala, Secretary of Health and Human Services).
96. This article uses the term "residential care facility" to refer generically to those facilities that provide care and supervision to residents, but are not nursing facilities, and thus are not subject to federal nursing facility law. Because residential care facilities are defined by state law, there is variation from state to state on the precise term used to refer to a "residential care facility." These terms include "personal care home," "assisted living facility," and "residential care facility for the elderly." See Carlson, supra note 11, §§ 5.02[1], 5.10.
The assisted living model is an unqualified hit in the court of public opinion. What’s not to like about assisted living’s typical image—a home-like environment, with assistance provided in exactly the amount to be adequate but not intrusive? Consider, and compare to the standard images of a nursing facility, the definition of assisted living produced by the National Center for Assisted Living, a trade association affiliate of the American Health Care Association:

An assisted living setting is: [a] congregate residential setting that provides or coordinates personal services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health-related services; [d]esigned to minimize the need to move; [d]esigned to maximize residents’ dignity, autonomy, privacy, independence, choice and safety; and [d]esigned to encourage family and community involvement.98

To date, the general public has not looked behind the superficial image of assisted living. The general-interest news media has discussed assisted living from a largely uncritical perspective, in a tone dramatically different from that used to discuss nursing facilities.

Two articles from *Time* magazine illustrate the differing tones. First, in an article representative of much of the nursing facility coverage, a 1997 *Time* article reports in its subheading that “[i]n possibly thousands of cases, nursing-home residents are dying from a lack of food and water and the most basic level of hygiene.”99 The article opens with a description of a “dungeon” of a nursing facility where bedpans are washed in the whirlpool bath and facility employees ignore screaming residents.100 The article closes with the story of a resident with a maggot-infested bedsore, with a quote suggesting that the California Department of Health Services approves the use of maggots for debridement of bed sores.101

By contrast, a 1999 article from the same magazine opens a discussion of assisted living102 with the story of an eighty-two year-old woman who moved to “a landscaped complex where about two dozen seniors live in their own apartments and have round-the-clock staff members to help with daily tasks such as dressing...
and bathing." Later pages feature photographs of residents baking, gardening, and exercising in pools, along with a photograph of a call-button pendant that evidently provides quick access to assistance.

Only in the last few paragraphs does the article acknowledge that an assisted living model may have some limitations. First, the article reports that assisted living is expensive, and that assisted living expenses, in general, are not covered under either the Medicare or Medicaid Programs. Then, in the final three paragraphs, the article suggests that "[the boomtown growth of the assisted-living industry has left it a bit rough around the edges." Quoting U.S. Senator John Breaux, the article notes that a "bottom-line mentality can lead to consumer fraud and abuse" in the assisted living industry; but responds with a sanguine paragraph that assumes uncritically that assisted living is part of an “evolution” towards improvement in long-term care:

Late-century American life is a social experiment in which we hope that market institutions can be fashioned to meet the most personal requirements. And sometimes they can be. New living arrangements for the elderly are still evolving. If that evolution isn’t finished in time for all our parents to take advantage of, for many of us there will be a second chance—when it’s our turn.

2. The Lack of Connection Between the Assisted Living Model and Purported Advantages

It should not be surprising that, as reported in the Time article, an expensive assisted living facility is able to provide pleasant living arrangements for individuals with relatively limited medical problems. But assisted living proponents claim a much broader advantage for the assisted living model: specifically, that an assisted living model will produce a higher quality of long-term care generally, regardless of residents’ financial status or medical condition.
Among other things, the assisted living model will liberate long-term care providers from the nursing facility laws that allegedly have prevented them from addressing consumers' needs and desires.\footnote{110} The proponents' claim may not stand up to scrutiny.\footnote{111} Recall the definition of assisted living—in brief, a setting or facility that provides necessary services, minimizes the need to move, maximizes a resident’s autonomy and privacy, and encourages family and community involvement.\footnote{112} Many of these criteria could be met by a well-run nursing facility. Specifically, although the nursing facility model concededly does not “minimize the need to move”—because nursing facilities are designed only for individuals with a certain minimum level of medical need—a nursing facility could, and should, provide necessary services while maintaining a resident’s quality of life.\footnote{113}

Indeed, federal law already requires nursing facilities to meet most of the criteria set by the assisted living definition. Under federal law, a nursing facility must provide the care and services that a resident needs to “attain or maintain the highest practicable physical, mental, and psychosocial well-being,” including but not limited to therapy services and assistance with daily necessities.\footnote{114} A nursing facility also must protect the resident’s privacy.\footnote{115} The nursing facility must allow visits by family members and others,\footnote{116} and formation by family members of a family council.\footnote{117}

The claimed advantages of an assisted living model simply are not explained by the legal differences between an assisted living model and a nursing facility.
model. In fact, the distinguishing legal features of the assisted living model—less stringent regulation, and more reliance on voluntary industry standards—contradict the many studies and reports that bemoan the leniency of current enforcement of nursing facility standards. The case for an assisted living model is also not easily reconciled with HCFA’s well-reasoned rejection of the South Dakota Quality Initiative, or HCFA’s similarly well-reasoned refusal to allow private accreditation to replace government enforcement. Resident advocates are justifiably “concerned that assisted living may become a code word for unregulated nursing homes or unregulated board and care homes with lax standards, bad outcomes, and consumer fraud.”

3. The Inability of Negotiated Contracts to Assure Adequate Quality of Care

Furthermore, the use of negotiated contracts in the assisted living model cannot substitute for adequate government regulation and oversight. Proponents of assisted living assume that market forces will guarantee an adequate quality of care. This argument ignores the fact that similar market forces assuredly have been insufficient to create high standards in the nursing facility industry.

The reliance on contracts is particularly suspect given the unfamiliarity of most consumers with long-term care, and the long-standing use by nursing facilities of illegal and deceptive contracts. For example, a recent study of California nursing facility admission agreements found, among other things, that 91.9% of the

118. See, e.g., ASSISTED LIVING INITIATIVE, supra note 97, at 40-51.
120. See supra notes 63-73 and accompanying text.
121. See supra Part V.B.
123. See, e.g., ROBERT L. MOLLICA AND KIMBERLY IRVIN SNOW, STATE ASSISTED LIVING POLICY: 1996 xi (1996) (state setting minimal standards, assuming that market forces will produce an adequate quality of care); Marshall Kapp, Enhancing Autonomy and Choice in Selecting and Directing Long-Term Care Services, 4 ELDER L.J. 55, 93 (1996) ("[T]he marketplace acting through client purchasing decisions best safeguards the client."); see also supra note 99 and accompanying text (concluding paragraph from Time magazine article on assisted living); Clarke, supra note 57, at 20 (vice president for nursing facility chain advocating use of admission contracts to define “responsibilities and expectations” in nursing facilities, to avoid “inconsistency and subjectivity of the current survey system”).
agreements listed an illegal justification for the resident's eviction, 78.5% illegally limited the facility's liability for an injury suffered by the resident, and 40.0% illegally restricted the visiting hours of the resident's family.\textsuperscript{125}

Indeed, assisted living contracts in practice do not support the idealistic claims of assisted living proponents. The General Accounting Office made a pessimistic evaluation of the status quo:

A recent limited survey of industry practices noted that contracts had no standard format, varied in detail and usefulness, and in some cases were vague and confusing. For example, none of the contracts examined mentioned how often services would be provided; a number of contracts stated only that services would be provided as the facility deemed appropriate. Furthermore, few specified what would occur if a resident's health status declined, such as what needed additional services would be provided, whether there are additional charges for these services, or whether the resident would be asked to leave because needed services could not be furnished.\textsuperscript{126}

Certainly contracts are not truly "negotiated," as shown by the fact that facilities use standard, pre-printed contracts. Worse yet, residents may not even see these contracts before making the decision to seek admission; according to another GAO report, only twenty-five percent of facilities provided copies of contracts to individuals considering admission.\textsuperscript{127}

Finally, assisted living contracts—like nursing facility admission agreements—may contain provisions that are illegal and/or unfair to residents. For example, many assisted living proponents assume that "negotiated risk" provisions of a contract would exempt the facility from legal liability for certain types of injury suffered by the resident.\textsuperscript{128}

\textsuperscript{125} ERIC M. CARLSON, "IF ONLY I HAD KNOWN": MISREPRESENTATIONS BY NURSING HOMES WHICH DEPRIVE RESIDENTS OF LEGAL PROTECTION 5-6, 11-13, 17-18, 29 (1998).
\textsuperscript{126} GENERAL ACCOUNTING OFFICE, GAO/HEHS-97-93, LONG-TERM CARE: CONSUMER PROTECTION AND QUALITY-OF-CARE ISSUES IN ASSISTED LIVING, 6 (1997).
VI. CONCLUSION

The nursing facility industry, as a whole, has a longstanding history of providing substandard care. Nonetheless, nursing facilities do not deserve quite the level of hostility that they receive in the news media and society. Yes, the reported horror stories are true and, yes, many facilities provide a shockingly deficient level of care, but among the nation's over 17,000 facilities are facilities with sincere management and committed, professional employees.

Ironically, nursing facility trade associations, although commissioned with the task of improving facilities' public image, bear significant responsibility for the continued poor performance of the nursing facility industry, and for the scathing reports and hostile press coverage that are the unavoidable progeny of substandard care. Although industry representatives claim publicly that they favor tough action against "bad apple" facilities, the representatives' lobbying and litigation have created a federal enforcement system that is virtually incapable of bringing "bad apples" into compliance.

Furthermore, by reflexively blaming government for the industry's own shortcomings, industry representatives have fostered a persecution complex that impedes progress at all levels. At a macro level, as discussed above, facilities' defensive attitudes and policies have hamstrung enforcement. At a micro level—relating to the care of individual residents—these same defensive attitudes cause facility operators to cut corners, deny services and, in general, treat residents and residents' family members as potential adversaries rather than valued customers. These attitudes and actions only confirm the public's general sense that the operation of a nursing facility is a distasteful and disreputable business.

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129. See, e.g., GENERAL ACCOUNTING OFFICE, CALIFORNIA NURSING HOMES: CARE PROBLEMS PERSIST DESPITE FEDERAL AND STATE OVERSIGHT, Report No. GAO/HEHS-98-202(1998); IOM REPORT, supra note 12, at 3 (1986) (history of poor care provided by nursing facilities); BRUCE VLADECK, UNLOVING CARE: THE NURSING HOME TRAGEDY 4-5 (1980) (same); McKnight Providers, supra note 51, at 24 (Urban Institute analyst seeing current problems "as a continuation of an ongoing saga that has plagued the nursing home industry for 30 years or longer").


131. See, e.g., Blankenheim, supra note 61, at 26 (president of American Association of Homes and Services for the Aging declaring support for "any reasonable plan that drives the chronically poor performers out of the nursing home business"); How to Assess the GAO Report?, McKnight's LONG-TERM CARE NEWS, Sept. 1998, at 89 (vice president of American Health Care Association claiming "zero-tolerance policy" for abuse and neglect of elderly).

132. See McKnight Providers, supra note 51, at 24 (Urban Institute analyst stating that "the emphasis on plans of correction rather than more rigid oversight has 'institutionalized a mediocre quality of care' across the board and failed to root out chronic offenders").

133. See, e.g., John O'Connor, The Sky's Not the Problem, McKnight's LONG-TERM CARE NEWS, Mar. 1999, at 39 ("In some ways, the industry seems to be afflicted with a Chicken Little mentality . . . . For providers, blaming current problems on the government, the media or other handy external forces may be good for venting, but little else."); Providers Cite Image as Industry's Biggest Challenge, McKnight's LONG-TERM CARE NEWS,
Thus, the long-term care industry needs a change of attitude. On the policy level, trade associations must recognize the need for effective enforcement of the nursing facility law, and for meaningful government standards for assisted living facilities. Individual facilities must put aside their defensive attitudes and focus their energies on providing a superior level of service.

Similar recommendations were recently made by Paul Willging, executive vice president of the American Health Care Association for fifteen years, who has been perhaps the principal spokesman for the nursing facility industry in recent years. Unfortunately, Mr. Willging made these remarks only after resigning from AHCA and taking a position in academia.\(^{134}\)

Ideally, Mr. Willging's successors will confront the problems in the long-term care industry before their resignations, and will take active steps to improve the quality of care provided by the nation's long-term care facilities. Absent such a significant change of attitude, long-term care facilities are likely to face increasing levels of enforcement actions and litigation, and will continue to be seen as the haunted mansions of our society.

\(^{134}\) Willging: Providers Should Share Blame, McKnight's Long-Term Care News, July 1999, at 10 ("Nursing facilities are partly to blame for their low standing among the general public, and they will have to do more to improve the quality of long-term care that is delivered. The statement is hardly unusual, until one considers its source: Paul R. Willging, Ph.D. Willging had been the executive vice president of the 11,000-member American Health Care Association for a decade and a half, until he resigned earlier this year.")