

An Ombudsman's Guide to the Nursing Home Reform Law

OMBUDSMEN AND CITIZEN ADVOCATE ACTION: THE KEY TO CHANGE FOR RESIDENTS

Introduction

The Nursing Home Reform Law of 1987 (NHRL) stands as model public policy both for the vision of its goals for residents and the process used for passage. Long Term Care Ombudsmen Programs and Citizen Advocacy Organizations provided the grass roots stories of resident suffering that served as a catalyst for change and defined the new standards. For those individuals and organizations involved, getting the law passed in 1987 seemed like an almost insurmountable challenge, but implementation of the NHRL has required even more diligent and sustained efforts. Twenty years after the NHRL passage, nursing home residents still experience poor care and neglect far too frequently. Ombudsmen and other advocates continue to exert unrelenting pressure for full implementation of the law. Residents depend on you. This Guide is your companion in that ongoing process, so crucial to fulfillment of the law's vision for residents.

The Vision:

Imagine if you will, Congressmen and Senators envisioning what it is like to live in a nursing home. Then realize that in 1987 they were able to translate that knowledge into a law that includes provisions for quality of care, quality of life and residents' rights for vulnerable elders. The legislators succeeded because your predecessors helped make the case for and craft the important words of the law and ensuing regulations. Three important provisions are:

Quality of Life: Nursing facilities **must** care for residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

Quality of Care: Nursing facilities **must** 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.

Residents' Rights: Nursing facilities **must** protect and promote the rights of **each** resident, including each of the following rights... and it lists eleven rights in detail.

Of course there are many other parts of the law, which support the achievement of these basic provisions. You will learn or refresh your knowledge about them with this Guide. But first, take note of some important words that are in the NHRL language:

- Notice that the law applies to **each** resident. That standard places an appropriate and heavy responsibility on nursing homes to meet every resident's individual needs.
- A second important word is **must**. Nursing homes have no choice but to meet these standards.
- The quality of life provisions say that the way care is given (manner and environment) must **promote maintenance and enhancement** of quality of life. Providing care is not enough, it must be done in a way that actively promotes quality of life.
- The quality of care provision is similarly proactive so each resident **attains or maintains the highest practicable mental, physical, and psychosocial well-being**. That standard means the bar for care can become higher and higher as staff understand better approaches to care for residents.
- **Residents' rights** are the underpinnings of the civil rights one takes for granted or actively protects prior to living in a nursing home. An example is the right to make decisions about care.

The Process:

Passage of the NHRL took **two decades** of work. The core elements of this success serve as an important model for how to collect the facts, make a case, gather support, and press for change when engaging in Federal, State, or local advocacy. Present day efforts for full implementation require the same process. Successful passage in 1987 was preceded by:

- **Consumer Advocacy** by residents, family members, ombudsmen and other community advocates across the country.
- **Congressional Hearings** by the Senate Special Committee on Aging and the House Select Committee on Aging in the 1970's and 1980's.
- **Progressive State Leadership** by advocates, legislators, and concerned citizens that designed resident assessment systems, strengthened residents' rights, required aide training, and sharpened their survey and enforcement activities.
- **Health Care Professionals** in hundreds of nursing homes who proved over and over again that good care is not only possible, but is also preferable, to residents and care-givers alike.
- **A Consumer Supportive Lawsuit**, Smith v. Bowen, in Colorado, spurred government action when the federal court in Denver ruled that the Department of Health and Human Services (HHS) had failed in its duty to assure quality of care for Medicaid residents of nursing homes.
- **A Seminal Study** on nursing home regulation by the Institute of Medicine (IOM), funded by the Health Care Financing Administration (HCFA, now called the Center for Medicare and

Medicaid Services or CMS) at the urging of Congress. Its 1986 report, Improving the Quality of Care in Nursing Homes, contained comprehensive recommendations for action by HHS and Congress.

- **Consensus/Coalition Building.** The Campaign for Quality Care (CQC) was formed by the National Citizens' Coalition for Nursing Home Reform, after the IOM report was issued. Through the CQC, national organizations representing consumers, health care professionals and providers worked together to develop consensus papers on major issues. These consensus positions were subsequently enacted into the Nursing Home Reform Law. The CQC relied heavily on the experiences of progressive state regulatory systems, the good care practices of committed staff in hundreds of nursing homes, and the advocacy experience of state and local ombudsman programs and other advocates and nursing home residents.

Following its 1987 enactment, the law's implementing regulations were passed, establishing rules for the Resident Assessment Instrument (RAI), Quality Assurance, Pre-Assessment Screening and Resident Review (PASRR), Nurse Aide Training and Certification, Professional Standards, Neglect and Abuse, Resident Rights, Care Planning, Restraint Reduction, Survey and Certification, and Enforcement. Enforcement was particularly difficult to promulgate because of the fundamental differences between resident advocates and the nursing home industry. The same strategies used to enact the law were critical to the implementation of the regulations.

Pending final regulations include Nursing Waivers (1992), Licensure of Administrators (1992), and Physical Restraints and Psychotropic Drug Monitoring by Consultant Pharmacists (1992). Issuance of final rules for the restraints are the most likely to occur.

The Challenge: NHRL Staffing Compromise Undermines Vision

The weakest part of the NHRL is the provision on nurse staffing. Ombudsmen and consumer advocates fought long and hard for specific federal staffing standards. In the end, that one issue threatened to derail passage of the law. Consumers and advocates had to compromise on this issue to save the other important provisions of the law. Consumers wanted nurse staffing ratios and had to agree to the wording, "sufficient staff to meet the resident's assessed needs." Consumers wanted 120 hours of CNA training, but had to compromise at 75 hours. These compromises have been the law's Achilles' heel and continue to undermine all provisions of the laws and regulations (See Issues Chapter IV-C, Professional and Paraprofessional Staffing). Advocacy efforts continue to strengthen staffing requirements. Ombudsmen and other advocates have doggedly pursued solutions through advocacy. Some highlights are:

- **Consumer Advocacy:** Ombudsmen's daily presence in nursing homes is reflected in the National Ombudsman Reporting System (NORS) data reflecting low staffing and more serious problems in resident care and serves to bolster Survey and Certification data.

Citizen Advocates provide independent pressure in nursing homes and make their findings public on websites, TV and Newspapers.

- **Congressional Hearings:** The Senate Special Committee on Aging hearings in the 1990s and continuing into 2007 repeatedly detailed neglect and harm to residents in U.S. nursing homes as a result of low staffing. Ombudsmen and other advocates support Committee staff by assisting with organizing hearings and providing testimony.
- **Progressive State Leadership:** As of 2000, 44 states had appointed a task force, and/or introduced legislation or regulations improving nurse staffing.
- **Health Care Professionals:** The independent Pioneer Network of excellent practices that stabilize staff began under NCCNHR's leadership and has achieved major positive inroads in improving care for residents. Ombudsmen have avidly promoted those practices. State survey agencies and the Center for Medicare and Medicaid Services have promoted Pioneer Network/culture change practices.
- **Consumer Lawsuits:** Residents have received such poor care due to lack of staff that many residents and their families have sought justice in the courts.
- **Seminal Study:** A 1990 Congressionally mandated CMS study, "*The Appropriateness of Minimum Nurse Staffing in Nursing Homes*," was finally completed in 2001. The results indicated that 90% of America's nursing homes do not have the 4.1 hours per resident day of nurse staffing required to provide basic care; 50% of U.S. nursing homes do not have enough staff to prevent harm. NCCNHR supports the John A. Hartford Institute for Geriatric Nursing's recommendation of a minimum staffing level of 4.13 hours per resident day – a ratio developed by consumers and validated by a consensus panel of stakeholders. Note that the staffing ratio in the government report and the ratio developed by consumers are very close.
- **Consensus/Coalition Building:** The Campaign for Quality Care, under NCCNHR's leadership, continues to work on building momentum for nurse staffing ratios. In the last several years, bills have been introduced in State Legislatures that include the NCCNHR standard. In addition, state coalitions, strongly supported by ombudsmen and advocates, have passed staffing legislation. Florida, California and Delaware are good examples.

This process, so dependent upon the daily work of ombudsmen and other advocates, builds the momentum for change.

This Is Your Guide: Have Fun Using It!

This guide provides both a quick and an in-depth presentation of the laws, regulations, and many other materials and points of reference. It is available both on line and in hard copy! The Guide provides ombudsmen and other advocates with a working reference for daily individual advocacy (complaint resolution), facility-wide change, and systemic public policy advocacy. Use this Guide as your companion to build successful advocacy skills and sustainable systems for quality of care and life for and with residents and their families just as this visionary law requires. Good Luck!

THE NURSING HOME REFORM LAW of OBRA '87 as amended 1988 – 2007

SUMMARY OF THE MAJOR PROVISIONS OF THE LAW

The Nursing Home Reform Law required sweeping changes in nursing home and survey agency practice. Implementation has been slow, and sustained quality of care is far from complete. This summary refers to the law and CMS regulations published primarily in 1992 and 1995 and Surveyor Guidelines published in 1999. Note: Sections on PASRR, Reimbursement, and Psychopharmacologic Drugs apply only to Medicaid.

NURSING HOMES: QUALITY OF CARE

- Nursing facilities (NFs) must conduct a comprehensive **assessment** of each resident within 14 days of admission. Nursing facilities must then reassess each resident at least annually, or when the resident's physical or mental condition changes significantly. Skilled Nursing Facilities (SNFs) must complete the admission assessment within 5 days. Assessment is the basis for a **plan of care** to organize services and activities to "attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident."
- According to the **Quality of Care** section of CMS's Long Term Care Facility Requirements, facilities, based on the comprehensive assessment and plan of care, must assure that residents' abilities and condition do not diminish "unless the circumstances of the individual's clinical condition demonstrate that diminution was unavoidable" in 12 care areas: activities of daily living; vision and hearing; pressure sores; urinary incontinence; range of motion; psychosocial functioning; naso-gastric tubes; accidents; nutrition; hydration; special needs; and drug therapy.

To support quality care, facilities must:

- Have a **medical director**.
- Have **licensed nurses** around the clock, including RNs every day for at least 8 hours.
- Use only **nurse aides** who, within 4 months of hiring, have completed a **training and competency evaluation** program, or a competency evaluation program, or who are already certified as indicated by their listing on the **state's registry**. Aides have to be competent to perform duties to which they are assigned, and must receive regular in-service education and performance review from the facility. The state nurse aide registry also includes information about confirmed

incidents of abuse, neglect or misappropriation of residents' property by an aide, and any statement by the aide.

- Have **physician** visits every 30 days for 3 months and then, every 60 days. In nursing facilities, visits may be conducted by physician's assistants, clinical nurse specialists or nurse practitioners, under physician supervision. In skilled nursing facilities, after the initial visit, required visits may alternate between personal visits by the physician and visits by a physician assistant, clinical nurse specialist, or nurse practitioner.
- Have a full-time qualified **social worker** in facilities with more than 120 beds.
- Have the services of a **qualified dietitian**.
- Maintain a **Quality Assessment and Assurance Committee**, consisting of the Director of Nursing, a physician, and three other staff members, which identifies quality problems and issues which require its action and implements plans to correct them.
- Have **activities** programs directed by qualified personnel that contain empowerment, maintenance and supportive activities.
- Have **rehabilitative** services available to all residents and have an independent consultant monitoring **psychopharmacologic drugs**.

NURSING HOMES: QUALITY OF LIFE AND RESIDENTS' RIGHTS

- Nursing homes must care for residents "**in such a manner and in such an environment** as will promote maintenance or enhancement of the **quality of life** of each resident."
- Residents have the right "to reside and receive services with **reasonable accommodation of individual needs and preferences**, except where the health or safety of the individual or other residents would be endangered."
- Under CMS's Long Term Care Facility Requirements, a resident has the right to "**choose** activities, schedules, and health care consistent with his or her interests, assessments and plans of care; **interact** with members of the community both inside and outside the facility; and **make choices** about aspects of his or her life that are significant to the resident."
- **Residents' Rights** established by the reform law include:

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- Immediate **access** to the ombudsman, the physician, and family members, and reasonable access to other visitors subject to the resident's consent;
 - Ombudsman **access to residents' clinical records**, with resident's permission and consistent with state law; resident access to view records within 24 hours of request and to copy within 2 working days;
 - Freedom from **abuse** and from chemical or physical **restraints** except for resident's safety or medical treatment;
 - Participation in **resident and/or family councils**,
 - Expression of **grievances** and receipt of a prompt response;
 - **Transfer or discharge** only for health, safety, or welfare of the resident or other residents, non-payment or facility closure; notice and right to appeal, with information on how to contact the ombudsman, and on facility's policies for bed-hold and resident's right to return to next available semi-private bed, if bed-hold period lapses.
 - **Protection of residents' funds** with quarterly accounting;
 - Right to information about **eligibility for Medicaid and Medicare** and **services covered** by the facility's or Medicaid's basic rate, and services for which the facility **charges extra**;
 - Access to **survey reports** and
 - Information about how to file **complaints** with the ombudsman or survey agency.

SURVEY ACTIVITIES:

The law requires that surveys, which are conducted by the licensure and certification agency (survey agency), must review **care received by a case-mix stratified sample of residents**, including:

- a review of the "quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment," and residents' rights, and

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- a review of written plans of care, and an audit of residents' assessments to "determine the accuracy of such assessments and the adequacy of such plans of care."
 - CMS's Survey Procedures prescribe the following **tasks for surveyors**:
 - Off-site survey preparation
 - Entrance Conference/On-site Preparatory Activities
 - Orientation Tour
 - Resident Sampling
 - Information Gathering
 - Provides a systematic way of gathering information to make decisions about facility compliance. Some important highlights include:
 - An holistic review of sampled residents (including care, quality of life, record review, dining observations),
 - Medication pass observation;
 - Quality assessment and assurance review, and
 - Kitchen and food service observation.
 - There are special “investigative protocols” to determine:
 - Sufficient staffing of nursing services,
 - Abuse prohibition,
 - Adverse drug reactions,
 - Dining and food service,
 - Avoidable or unavoidable pressure sores, hydration and unintended weight loss.
 - Information Analysis and Decision-making
 - Exit Conference

Survey agencies are required to **notify the ombudsman of findings of non-compliance and enforcement actions** and **contact the ombudsman at the start of the survey** for information about the facility.

Surveys must be **unannounced**. Fines up to \$2000 are imposed on anyone who notifies a facility of a survey. To increase the **element of surprise**, surveys can occur from **9 to 15 months** after the previous survey.

ENFORCEMENT

The NHRL authorizes states and the federal government to use a **range of alternative remedies** in addition to decertification when a facility fails to meet standards, including:

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- **Ban on payments for new Medicare or Medicaid admissions** – must be used if facility is deficient in 3 consecutive surveys or fails to correct deficiencies within 3 months.
 - **Civil fines**, which must be more severe for chronic non-compliance and which can be imposed for deficiencies that have since been corrected.
 - **Temporary management** to oversee facility operations and assure the health and safety of residents until the facility is sold or improvements bring the facility into lasting compliance.

States and the federal government must set **criteria** for when and how each remedy is used to **minimize the time** between identification of violations and final imposition of the remedies and to provide **incrementally more severe** fines for repeated or uncorrected deficiencies.

States and federal government may levy fines for situations in which a nursing facility now meets the requirements, but was in **violation at a previous time**.

State agencies must have **sufficient staff to respond to complaints and to monitor, on-site**, facilities found or believed to be out of compliance with the requirements.

REIMBURSEMENT:

State Medicaid plans, submitted for CMS approval, must cover the cost of care "taking into account the costs of services required to attain or maintain the highest practicable mental, physical, and psychosocial well-being of each resident."

PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR):

Facilities may not admit any person with serious mental illness or mental retardation unless s/he has been evaluated by the state to determine his/her **need for nursing home services and for specialized services**. States must review annually, all mentally ill and mentally retarded residents to determine if they need nursing home care and if they need specialized services. Those residents found not to need nursing home care or specialized services must be transferred from the facility. Those needing specialized services and not needing nursing home care, who have resided in the facility for 30 months, may choose to remain in the facility or move to another setting and receive specialized services. Those needing specialized services and not needing nursing home care, who have resided in the facility for less than 30 months, must be transferred to another setting. The state must assure that all current residents who need specialized services receive them.

Persons with a diagnosis of Alzheimer's or related dementia are not "mentally ill" under PASRR unless they also have a primary diagnosis of serious mental illness.