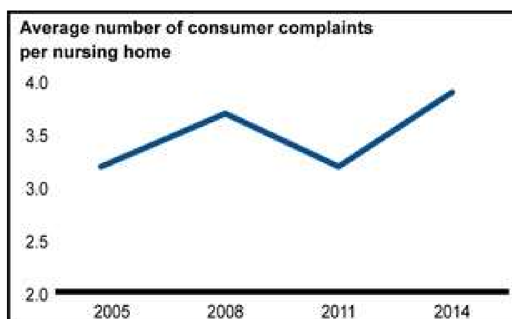
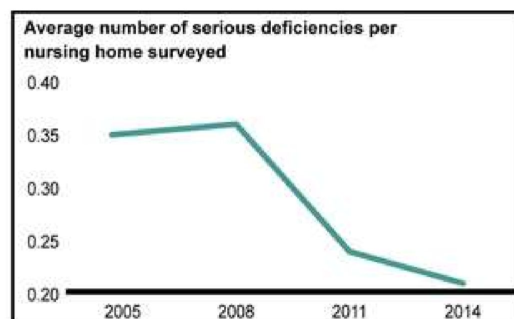
Epilogue --
The Need for Constant Vigilance;
"Residents Still in Jeopardy"

"The price of liberty is eternal vigilance," said Thomas Jefferson.

Similarly, constant vigilance is necessary to protect nursing home residents from neglect and mistreatment, which have been recurring and persistent problems.

Some facts regarding nursing home oversight raise the question: **"Are residents still in jeopardy?"** For example, this book has performance charts showing clearly that some trends regarding nursing home oversight have gone in the wrong direction in recent years.





Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-16-33

Ironically, numbers of consumer complaints about nursing homes have increased substantially while government oversight agencies have been issuing fewer citations for serious deficiencies and taking fewer enforcement actions.

To take a brief look back, in March 1998, then Pennsylvania Auditor General Robert P. Casey, Jr., (D) now a U.S. senator, released an audit report about the Pennsylvania Department of Health's (DOH's) oversight of nursing homes. It was entitled, "Residents in Jeopardy." Shortly thereafter, he released another audit report on the same subject, aptly entitled, "Residents Still in Jeopardy."

In a 1998 news release referring to the two audits, Casey said the Pennsylvania DOH had "failed miserably" in its oversight of nursing home care and that audit findings were "alarming."

Casey cited statistics showing that in 1996 the DOH issued only 45 sanctions against nursing homes, 58 fewer than it issued in 1994, a year in which there were 41 fewer nursing homes in Pennsylvania. I myself found that, amazingly, in 2012, DOH took only <u>two</u> enforcement actions. Apparently, the heightened vigilance that followed the 1998 Casey audits faded away almost completely by 2012.

Evoking a sense of déjà vu, Auditor General Eugene A. DePasquale said in a July 2016 audit report: “By some standards, nursing home care in Pennsylvania is declining.”

In 2012, after the death of my mother, Mary Regina, in August 2011, I suggested to a former Pennsylvania auditor general that he audit state government’s oversight of nursing homes. I wrote, “I would be happy to provide details supporting a conclusion that the oversight is not effective, is a waste of money, and fails to protect nursing home residents.”

In responding, a deputy auditor general referred me back to the Casey audits from the late 1990s. She pointed out that corrective actions were taken as a result of those audits. Also, she said, a “task force” was established to improve the oversight of nursing homes. She added, “Your suggestion that still more improvements are needed is one that I will keep on hand.” She said my audit suggestion would be considered for inclusion in the next year’s audit plan.

However, in the next year, a different auditor general took over the office. No significant audit of nursing home oversight in Pennsylvania was done between 2000 and 2015, when more sensational negative news about nursing

homes erupted in the media and a newly appointed secretary of health requested an audit of the DOH.

I noted that in 2011 Mary Regina had fallen victim to some of the same problems disclosed by the 1998 audits. Neglect of dehydration contributed substantially to her downfall, as it had for a victim cited in a 1998 Casey audit. Casey in 1998 deplored the dehydration case as one of numerous examples of “late and lax investigations of life-threatening nursing home complaints.” Also, in 2011 Mary Regina and I had not been able to obtain enough information to properly choose a nursing home. That problem had been cited in a 1998 audit as well.

Further, as noted, the DOH issued only two enforcement actions for the entire year of 2012, the year of my official complaint about my mother’s nursing home. The number was so unbelievably low that I had to ask the Office of the Secretary of Health to verify its accuracy. The office did verify it, in an email.

A chart in Chapter 9 of this book, provided by the secretary of health who took over the job in 2015, shows that enforcement actions in Pennsylvania generally trended down from 2002 until 2015.

On the national level, the Government Accountability Office (GAO) reported that the average number of

consumer complaints filed per nursing home per year increased 21 percent from 2005 to 2014, while the number of serious deficiencies cited by inspectors/surveyors per nursing home surveyed per year decreased 41 percent over the same period.

The Centers for Medicare & Medicaid Services (CMS), which oversees nursing homes at the national level, also reported a decline in the average number of deficiencies cited per nursing home surveyed from 2006 to 2014.

A CMS official attributed the decline in citations largely to cuts in state oversight due to the "Great Recession," although other factors have been mentioned. Concerns also were being raised about the reliability of CMS's Five-Star Rating System for nursing homes, including issues discussed in a December 2016 GAO audit report. The rating system did not consider the opinions of the people who were living in the nursing homes.

The national nursing home operators' association, which contributed $1,298,000 to federal election candidate campaign committees from January 1, 2015 through December 31, 2016, attributed the decline in deficiency citations to an improvement in care. The association also complained that nursing homes were overburdened with costly regulations, were plagued by allegedly unfounded

lawsuits, and that Medicaid's payments were insufficient to cover the cost of care.

Meanwhile, the Pennsylvania attorney general alleged in a lawsuit filed in 2015 that some nursing homes in Pennsylvania, although "enormously profitable," were not adequately staffed to deliver the services they were getting paid for, and that nursing homes in many cases knew in advance when the state inspectors were coming for "unannounced" inspections.

Two consecutive attorneys general in New Mexico alleged in a suit similar to the Pennsylvania one that staffing in certain nursing homes was not adequate to provide the services for which the homes were billing. Pennsylvania and New Mexico attorney general suits were still ongoing in 2017. Suits filed by presumably unbiased government attorneys describe shocking conditions in nursing homes that allegedly resulted from inadequate staffing.

The current Pennsylvania auditor general, another presumably unbiased government official, said in an audit report in July 2016 that the DOH was not properly monitoring the staffing of nursing homes, at the same time evidence of poor resident care was being disclosed. The 2016 audit report also repeated the finding from 1998 that

consumers were not getting enough information with which to choose a nursing home.

Two Pennsylvania newspaper reporters, Daniel Simmons-Ritchie and David Wenner, in a 2016 series of articles entitled "Failing the Frail," by PennLive.com/the *Patriot-News,* found that among 259 deaths due to serious incidents in Pennsylvania nursing homes from 2013 to 2015, nursing homes were cited by the DOH for a care-related death in only 46 cases. The state decided penalties were unnecessary in more than half of the 46 cases. The journalists said it was common for the DOH to understate the severity of deficiencies in fatal cases.

Just as in 1998, a task force was established in 2015 in an effort to improve the quality of nursing home care and oversight in Pennsylvania. As part of its work, the task force commissioned a limited survey of nursing home residents to obtain their input for the task force report, which was published in October 2016. Among the findings of the focus-group-style survey, which included 29 residents from six representative nursing homes, was that 62 percent of the survey participants were "very dissatisfied" with the quality of physical care provided; they believed the staff-to-resident ratio was inadequate; and they waited an average of 45 minutes to 1 hour for responses to call bells.

Although I know that many people are working hard to improve nursing home care, I wonder whether some aspects of care have improved much since my mother was in a nursing home in 2011. I remember that response time to call bells was disgraceful in my mother's nursing home, but I do not remember it being as bad as an hour, as was indicated in the 2016 task force survey report.

I observed that quite a few nursing home residents must have endured almost incessant ringing of nurse call bells between 2011, when my mother complained of it, until 2016, when long waits for responses were cited in the Pennsylvania task force report. Mary Regina's nursing home was rated below average in 2011, and it was rated below average in 2016.

I remember that during my mother's stay in the nursing home, few residents seemed to get visitors. There also were few, if any, people to speak up for some residents.

When the residents were asked as part of the 2016 task force survey, "What is the difference between a good day and a bad day," one responded: "When I have someone to talk to."

Notably, the survey of "what the residents think" was not mentioned in the Pennsylvania DOH's news release

announcing the task force report, and the survey of what residents think got virtually no mention in the news media.

I found as I was working on this book that even as a former journalist whose book was likely to be circulated widely, I had difficulty getting government officials to respond to my inquiries. In some cases, I was told to submit Freedom of Information Act (FOIA) requests. It seemed that instead of facilitating citizens' access to public information, the FOIA created a virtual holding bin where citizens' requests for government information could be sent with impunity for indefinite periods instead of being answered.

I received a reply on May 2, 2017 to an FOIA request I had sent 8 months earlier on August 29, 2016 to the CMS FOIA officer. The response's 36-pages of information, some of which was not about nursing homes, did not seem to contain explicit answers to the four specific questions I asked in my FOIA request. (In fairness, I must say that three CMS officials were helpful to me in other matters over the course of my research. See Appendix E.)

In one case, questions I submitted to a senator in five different ways -- by email, paper mail, a web site, a fax, and telephone voicemail -- seemed to have been sent into a black hole on Capitol Hill. There was no reply at all.

Meanwhile, it seemed to me that elected officials and agencies -- CMS, for example -- were well staffed and prolific at creating and issuing seemingly self-promotional, politicized, news releases that tout their purported successes. Many news releases praised the Affordable Care Act, even though popular opinion and the November 8, 2016 presidential election results seemed to indicate that the success of the Act was a debatable issue.

One CMS release on December 2, 2016 said per capita growth of health care spending "continues to be below the rates of most years prior to the passage of the Affordable Care Act." It quoted the acting CMS administrator as saying: "Our significant progress in reducing the nation's uninsured rate, while providing strong protections for Americans if they get sick, would not be possible without the Affordable Care Act." It added, "As millions more Americans have obtained health insurance, per-person cost growth remains at historically modest levels." I noted that the releases used vague words such as "most," "significant," "strong," and "historically modest."

A CMS news release headline on August 9, 2016 said: "Affordable Care Act payment model continues to improve care, lower costs." Two weeks later on August 25, 2016 a CMS news release carried the headline: "Physicians and

health care providers continue to improve quality of care, lower costs."

Expressing an opposite view, President Donald Trump's eventual appointee as secretary of health and human services, physician Congressman Tom Price, said on October 25, 2016:

"While President Obama and Democrats have the audacity to tout Obamacare's 'success,' the cold hard facts and figures prove the opposite is true. Every single day Obamacare is making the quality of health care in this country worse and next year alone, benchmark Obamacare premiums are set to increase 25 percent on average for states that use the federal healthcare market place."

Whatever one's political persuasion, the involvement of politics in health care, including nursing home care, should be quite evident.

One Democrat state auditor general actually was quoted in the Pennsylvania press as saying he thought a former Republican governor's administration banned acceptance of anonymous complaints about nursing homes "to silence critics." Enforcement actions were way down in the state under that governor's administration, as they were nationally under the most recent Democrat president.

Kathleen Kane, the elected Pennsylvania attorney general who at least appeared to be crusading for better nursing home care, was sentenced to 10-23 months in prison in October 2016. She had been convicted of perjury and of disclosing grand jury information to discredit a political enemy. Although an unusual case, it does not inspire confidence in government as an overseer of nursing home care.

Kane, a Democrat, was embroiled in political wars and claimed she was fighting a “good old boys” club. She was accused of stifling a corruption investigation of Democrat politicians that had been initiated by her Republican predecessor. A scandal Kane exposed about a pornography email network in state government touched officials in the Republican governor’s office and reportedly led two state Supreme Court justices to resign. News coverage of the scandal included reports of infighting between individual Supreme Court justices themselves. As this book was being published, the Pennsylvania Supreme Court, which had lost two members to Kane’s pornography expose’, was adjudicating an appeal regarding a big nursing home lawsuit that Kane had filed before her demise.

Evidence of the interlacing of politics in nursing home oversight that is more obvious is the extent of political campaign contributions passing between health providers

and elected officials, which is discussed in other parts of this book. An "obvious" example of the access the nursing home industry has to politicians is a June 12, 2017 news release photo of American Health Care Association President and CEO Mark Parkinson, a former governor of Kansas, and other AHCA officials, meeting with new U.S. Health and Human Services Secretary Price at HHS. The news release is posted on my website: https://www.wbeerman.com/ahca-members-meet-with-hhs-secretary/.

Government officials, such as governors, appoint those who run the agencies overseeing nursing homes. Some such appointees may not want to see the governor or some other official who appointed them be embarrassed by bad publicity about nursing homes. Most likely there is pressure to suppress nursing home scandals or spin the news. I wonder whether Kane's disclosure of embarrassing facts about state government's lax oversight of nursing homes helped foster political animosity toward her.

Kane's lawsuit disclosed suspicious circumstances surrounding allegations that a considerable number of nursing home managers knew when the government inspectors were coming for "unannounced" inspections.

On a tangential issue, HHS Secretary Price, a doctor who received almost a half-million dollars in campaign

contributions from the health sector in 2015-2016, favors limiting potential jury awards to patients in health care cases as a way to keep costs down. The term, tort reform, being advocated as a part of health care reform, refers to proposed changes by legislators that aim to reduce the ability of victims to bring litigation or to reduce the damage awards they can receive.

In my experience, it was, and is, already difficult to undertake lawsuits on behalf of elderly victims of alleged health malpractice. Some lawyers, although not all (See Appendix D), see cases regarding elderly people as having low potential for substantial awards because older people, especially retired persons, do not lose many years of lifetime earnings potential, or even many years of life expectancy, when injured. Also, in many cases, Medicare and Medicaid must be repaid for their patient-care expenditures out of lawsuit settlement funds, which substantially decreases any award proceeds that may be left for the victim. This scenario is unfavorable for nursing home residents or their families who seek legal recourse.

Nevertheless, as detailed in the book, I found in my research that some lawyers -- state attorneys general, for example, and private-practice nursing home specialists – sometimes seem to have more success in holding nursing homes accountable than do government oversight agencies

set up for that purpose. The attorneys are able to put to good use in court the records that government oversight agencies create through their inspections and administrative work.

On November 2, 2016, I heard a story that touched my heart. New Mexico Congressman Steve Pearce related in a speech that while he was flying a C-130 during the Vietnam War, he listened in on the radio as an American fighter jet with two crew members was shot down. The downed crew asked over the radio that they be picked up by a nearby rescue helicopter. One of the two was picked up -- he was in the water. The other crew member was on land.

"The Rules of Engagement required the rescue helicopter to get clearance to pick up the one who came down on land," recalled Pearce. "That clearance had to come from command headquarters in Hawaii. But darkness had set in before the clearance was received back from Hawaii. Throughout the night over the open mic, rescuers heard automatic weapons. The next morning, contact with the lone crew member was attempted, but fate had already decided his way."

This reminded me that just as the airman was a victim of a policy decision made remotely, people in all walks of life who are in need of rescue of some sort become victims of slow action, non-action, or bad decisions by government

officials and employees. Many residents of nursing homes, like the one who said a good day is “when I have someone to talk to,” suffer alone. As things stand now, one must wonder whether they will be rescued.

I noticed that much of the CMS management data about the performance of nursing homes and oversight agencies is a year old, or even much older, which may indicate slow processing.

Although in 2010 the Affordable Care Act added an enforcement requirement for CMS to establish an automated system for collecting payroll data on nurse staffing hours in nursing homes, that requirement still had not been fully implemented in mid-2016.

After members of Congress requested an audit of the Five-Star nursing home rating system in August 2015, the audit report did not come out until November 2016, which is not exceptionally slow for an audit report. The corrective actions recommended by the auditors routinely will come some time after the audit, if at all. Nevertheless, auditors, especially GAO, along with attorneys and advocacy organizations, seem to be among the best friends of nursing home residents.

Yet, 1 hour or 1 day, or 1 year or 5 years, can be a long time for someone suffering in a substandard nursing home and waiting to be rescued.

As this book was being prepared for publication, Congress was debating repeal and replacement of Obamacare, changes to Medicaid, and limits on healthcare litigation. The outcomes of these deliberations will have serious consequences for nursing home consumers.

Meanwhile, nursing home operators were contending that Medicaid payments were already $23-$25 per resident per day, or $7 billion per year nationally, short of what they needed to comply with standards of care.

Expecting that poor conditions in some nursing homes would not be corrected soon, I decided that I would plan to write a sequel to this book. For the sequel, I will solicit information from residents, nursing home staff, state enforcement staff, federal officials, and others about conditions in nursing homes. I especially would like to know whether consumers are happy with the way state agencies investigated their complaints.

So, interested persons are invited to provide information about the performance of oversight agencies, conditions in nursing homes, and efforts to improve

conditions, for the sequel, at my web site, *https://www.wbeerman.com*.

Since information provided to me will be used only for the preparation of the sequel, I hope people will also report complaints to government agencies and seek help from advocacy organizations for nursing home residents such as those mentioned in Chapter 15, which may be able to provide timely help.

God willing, if I live long enough, I will publish a progress-report sequel sometime in the future. Maybe it will be called, "*Mary Regina's nursing home – Residents* ***Still*** *in Jeopardy*." But I hope I will be able to call it something different.