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ISSUES BRIEF: Nursing Homes – Oversight, Licensures, Closures

Issue: The Department of Public Health (DPH) is the first line of defense to protect nursing home residents and their rights.

Goal: Sufficient and well-trained surveyors and complaint personnel, strong nursing home oversight with meaningful financial penalties for noncompliance; a comprehensive licensure vetting process (including management companies); and nursing home closure requirements that include the voices of all stakeholders and ensure the safety and well-being of residents transferred to new locations.

Problem Statement: Government studies cited below and recent experience indicate additional DPH surveyor and complaint personnel are needed, and overall oversight must be strengthened. Regulations addressing the following areas must ensure comprehensive oversight, meaningful licensure process, and closures that ensure the safety and well-being of residents, including transfers to new locations.

Background: Recent GAO, OIG, and MA studies have shown serious issues with MA DPH oversight regarding failing to perform timely investigations of high priority complaints; failing to conduct investigations of mistreatment cases within required timeframes, potentially putting residents in prolonged physical or financial harm; and failing to reign in infection prevention/control deficiencies for multiple consecutive years.[1]

Skyline and Synergy facilities are two tragic examples of the need to strengthen fundamental nursing home ownership and management requirements, including any related-party transactions, enhanced character, and competency review of all, etc.

To protect nursing home residents from suffering medical or psychological problems from transfer trauma when a facility closes, the facility should stay open for at least 90 days to ensure sufficient time for relocation. Good communication with residents, their representatives, and staff, plus closure rules for staffing, are also important.

Recommendations:

1. **Strengthen regulatory oversight of nursing homes,** including timely investigations and complaint responses, and meaningful enforcement of state and federal regulations, particularly reducing "no harm" designations.
2. **The Commonwealth must increase DPH resources,** to hire the necessary qualified staff to handle all responsibilities.[2]
3. **Strengthen vetting of new nursing homeowners (including implementing provisional licensure) and management companies** to ensure qualified new ownership and in-state management preferable.
4. **Improve nursing home closure process to ensure resident protections —** in addition to above protections, place residents in safest and closest nursing home and evaluate residents for community placement when appropriate.
5. **Encourage repurposing of closed nursing homes to other residential and/or service needs.**

For more information, please contact Facilities Workgroup Chair: Arlene Germain, agermain@manhr.org.

Endnotes

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[1] 1. **Since 2020, two Office of Inspector General reports on DPH operations in 50 states:**

- U.S. Health and Human Services Office of Inspector General, January 2022, OEI-06-19-00460: https://oig.hhs.gov/oei/reports/OEI-06-19-00460.asp.
  2015-18: MA DPH failed by large margins to meet 95% threshold to initiate surveys of high-priority complaints within 10 days.
  Page 9: Several States not only failed to meet the same performance measure in each year, but their scores were far below the performance threshold. For example, MA failed to meet the "95% threshold to initiate surveys of high-priority complaints within 10 days" by a large margin in all 4 years of the study period. In FY15, the State conducted only 31% of required surveys and then dropped to 17% in FY16. In FY17, the State score improved to 36%, still well below the 95% performance threshold. In FY18, MA score for this requirement fell to 19%.
- Office of the Inspector General (OIG*), States continued to fall short in meeting required timeframes for investigating nursing home complaints: 2016-2018*, September 2020, OIG OEI-01-19-00421, *Data Brief,* Results page 6, https://oig.hhs.gov/oei/reports/OEI-01-19-00421.pdf
  2011-18: MA DPH one of only 10 states that failed to perform timely investigations of high priority complaints for 8 consecutive years.

2**. May, 2020 General Accounting Office report on infection control in nursing homes:**
Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic, General Accounting Office, 5/20/20, https://www.gao.gov/assets/gao-20-576r.pdf.

- Nursing home cited in multiple consecutive years is an indicator of persistent problems:
  - ➢ 15.5% of MA nh [66 MA nh/427] were cited in multiple consecutive years.
- The GAO analysis of CMS data showed that infection prevention and control deficiencies were the most common type of deficiency cited in surveyed nursing homes, with most nursing homes having an infection prevention and control deficiency cited in one or more years from 2013 through 2017.
  - ➢ 63.7% of MA nh had an infection prevention or control deficiency cited in 1 or more years during that 5-year period.

  [Table 3, page 10: 63.7% = 272 MA nh cited for infection prevention and control deficiencies (427 Total MA nh minus 155 nh with no infection prevention and control deficiencies cited)/427 Total MA nh.]

3. 9/11/19 Auditor of the Commonwealth audit covering Department of Public Health for the period 7/1/16-6/30/18: Official Audit Report – Issued September 11, 2019: https://www.mass.gov/doc/audit-of-the-department-of-public-health-dph/download.
Major finding DPH didn't prioritize and conduct investigations of mistreatment cases within required timeframes, which could result in prolonged physical and financial harm to residents. In addition to required timeframes not being followed for higher priority cases, the audit found DPH did not perform all required onsite surveys, did not refer some cases to the Attorney General's Office as required, and did not have adequate case tracking and monitoring procedures in place. In its response to the audit, DPH cited numerous backlog issues for case intake due to a lack of resources and understaffing.

[2] The 2/28/22 Biden Administration nursing home initiative will provide nearly $500M to CMS to fund health and safety inspections. This funding will go to both CMS and the states to increase inspections in nursing homes. As of an April 2016 presentation by Secretary Sudders to the Public Health Council, DPH had 77 inspectors employed, with ten vacancies.

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