Coalition for Quality Care
A National Organization of Regional and State Citizen Advocacy Groups
Working Together for Quality Long-Term Care

Improving Nursing Home Care: Consumer Priorities for CMS

The Coalition for Quality Care (CQC) is a nonprofit organization comprised of state and regional long term care Citizen Advocacy Groups from across the United States. CQC's members join together to work to improve the quality of care and quality of life for the millions of Americans who depend on long term care, including nursing home and assisted living residents as well as those who receive home and community-based care. This policy brief discusses the basis for consumer and public interest in nursing home quality assurance and presents recommendations to strengthen our government's efforts to ensure that every nursing home resident is provided the quality of care and of life that is mandated by the law and which we all deserve.

CQC members represent a diverse range of consumer stakeholders. Some are run entirely by volunteers (often including residents and families) while others are professionally staffed. A number of CQC members help residents and families directly while others focus on systemic advocacy. The following is based on this range of perspectives and expertise.

For further information or questions about this policy brief please contact Richard J. Mollot at richard@ltccc.org or 212-385-0355. For more information on CQC, including our 2013 report, *Stakeholder Perspectives on Nursing Home Survey Effectiveness*, please visit our homepage: www.coalitionforqualitycare.org.

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I. Basis of Consumer Interest in Quality Standards & Enforcement

Nursing homes play a central role in long term care across the United States. Approximately forty percent of Americans who reach senior status will require nursing home care at some point. In addition to those who will directly depend on nursing homes for their health care and quality of life, those individuals' families and loved ones also have a stake in the quality of our country's nursing homes. And beyond these stakeholders' personal interest, the enormity of public funds spent on nursing home care (in 2012, taxpayers spent over $80 billion for nursing home and CCRC care[1]) means that all Americans have a stake in ensuring quality and value in the nursing home sector. In short, because nursing homes provide an essential public service with predominantly public funding, it is essential that they be held accountable for providing good care and good value.

While it thus may seem self-evident that resident safety and citizen priorities should be paramount when standards are developed and enforced, historically that has not often been the case. Residents and their representatives rarely have a "place at the table" when legal, policy or regulatory issues are addressed, while providers and their lobbyists have been the dominant "stakeholder" voice in such discussions since well before the advent of our current legal and regulatory framework over 25 years ago (with the passage of the Nursing Home Reform Law in 1987).

Changing perceptions of consumers' rights in general, and our understanding in particular that elderly and disabled people have the same rights as other citizens to attain and maintain their highest practicable medical, social and emotional well-being, make it clear that a rebalancing of the priorities and perspectives regarding nursing home regulation and oversight is long overdue.

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[1] Historical National Health Expenditure Data for Medicare and Medicaid from CMS (accessed at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html). Note: The data table does not separate nursing homes from CCRCs.

II. The Consumer Perspective on Nursing Home Oversight & Accountability

A strong and effective nursing home survey system is essential to ensure both resident safety and the integrity of the public programs which pay for a majority of nursing home care. Surveyors are the only individuals with authority to enter a nursing home at any time, evaluate performance and impose sanctions. The fundamental purpose of this authority is critical: to ensure that the minimum quality of care and quality of life standards are enforced for all residents in these facilities.

Because residents are often very frail and vulnerable, meaningful oversight and effective enforcement are crucial. Unlike consumers in most other situations, nursing home residents cannot, in general, just walk out the door when faced with inadequate services or inhumane treatment. Their lives, quite often literally, depend on the nursing home provider. In addition, given the enormity of public funding involved, enforcement also directly affects that value we receive as taxpayers and our ability to hold providers accountable for their use of public funds.

A Common Thread:

Federal and state oversight efforts are failing, in significant ways, every day, to ensure that nursing home care, quality of life and resident dignity meets minimum standards.

In both the development of this system over the years and its implementation, the nursing home industry and its lobbying associations have often had a disproportionate influence in the development and enforcement of regulations, guidelines and other policies and in the implementation of programs intended to ensure that their members—who are entrusted with billions of dollars in public funds—comply with laws enacted to ensure the protection of Medicare and Medicaid beneficiaries. There has not been a commensurate level of attention to the concerns and recommendations of those who speak directly for the citizens of this country, in particular the residents of these facilities, their friends and families, and those who work to protect them. As a result, year after year, reports of widespread neglect, abuse, noncompliance and ineffective enforcement continue. We believe that the relative paucity of influence in vital decisions by Citizen Advocacy Groups, the Long-Term Care Ombudsman

Program, and other groups and experts with understanding of consumer perspectives reflects a significant and dangerous functional bias toward the industry.

III. Recommendations

A. RESTORE FAITH IN NURSING HOME OVERSIGHT

As noted above, CQC members represent a broad range of consumer voices. A common thread that runs through our varied perspectives is the strong sense that federal and state oversight efforts are failing, in significant ways, every day, to ensure that nursing home care, quality of life and resident dignity meets minimum standards.

This speaks to two issues: one, of course, is the widespread failure of nursing homes to provide decent care. The second is the failure of the state agencies and CMS to both adequately identify poor care, abuse and neglect and to hold providers accountable when these situations are uncovered. While these may seem to be largely the same issue, they are, in fact, distinct in important ways: not only do nursing homes systematically fail and dehumanize their residents; when those residents and their families turn to the state they often face not only a failure to act, but a failure to even acknowledge the existence of a problem.

"As a result of these cascading breakdowns, nursing homes fail to meet minimum standards with impunity and residents and families across the country have substantially lost confidence in the system…."

As a result of these cascading breakdowns, nursing homes fail to meet minimum standards with impunity and residents and families across the country have substantially lost confidence in the system and the agencies charged with ensuring quality. While many CQC members know of individual survey staff who do a "good job," on the whole we simply have little faith that the state or federal agencies are willing and able to protect residents and enforce the minimum standards established in the Nursing Home Reform Law.

Specific Recommendations:

1. Basic Survey Agency Improvements and Safeguards are Needed

Fundamentally, the State Survey Agencies (SAs) must be sufficiently directed and held accountable for protecting residents and ensuring that nursing homes are meeting the standards for which they are being paid to achieve. To that end, we call on CMS to require:

i **Separation of Industry & State** - In order to ensure the basic integrity of both state and federal survey offices and avoid conflicts of interest, survey and certification staff should maintain professional separation from the industry and industry related activities and not participate in quality improvement initiatives or other collaborative activities designed to improve care practices. These collaborations not only give the *appearance* of impropriety, but our experiences also frequently indicate that state and federal survey officials *speak* and *act* as if the nursing homes are their partners whose interests they are obligated to serve and protect, even at the expense of resident safety, dignity and well-being.

   a. Nursing home standards have been in place for over two decades.
   b. Providers agree to meet or exceed these minimum standards when they contract to provide Medicaid and/or Medicare services.
   c. Given especially the vulnerability of the majority of people entrusted to their care, there should be zero tolerance for failing to meet standards.
   d. Thus, it is highly inappropriate, as well as an enormous disservice to both residents and taxpayers, for CMS and the states to collaborate with providers that fail or harm their residents to help them meet the minimum standards which they are already being paid to achieve. We believe that this is an inappropriate use of any state or federal agency resources. However, when it involves the very offices and staff that are supposed to be ensuring that residents are protected, it is a particularly abhorrent betrayal of the public trust.
   e. If, despite the generations of residents and tens of billions of public funds spent on care since 1987, providers *still* need on-the-job training, the QIOs and numerous other public and private agencies are equipped to help them improve care and

better understand the legal and regulatory standards of care which they have agreed to achieve (or exceed) for every resident.

ii **Integrity Within Agencies** - Ensure integrity of state nursing home survey & certification offices by requiring that they be separate, in terms of operations, budget and staffing, from other departments or staff within the agency.

iii **Appropriate Funding** – Each state should be expected to provide a standardized amount of funding for nursing home oversight activities, proportional to the federal financing it receives to conduct these activities and the size of the state's nursing home population. States that fall short of these expectations should, minimally, receive heightened scrutiny of their performance to ensure that they are effectively enforcing nursing home standards and responding to complaints.

iv **Verified Effectiveness** – States should be required to track survey team enforcement rates, including numbers of citations and scope and severity levels of citations, and assess survey teams' enforcement rates in respect to:

a. Validated nursing home quality measures;
b. Verified nursing home direct care staffing levels;
c. Civil or criminal actions against nursing homes and their personnel, including those of the Medicaid Fraud Control Units and other Medicaid integrity agencies; and
d. By auditing Statements of Deficiencies to identify instances where scope and severity do not appear to have been properly rated.[2]

v **Meaningful & Consequential Performance Review** - CMS should improve the quality and specificity of SA performance review criteria so that survey outcomes more closely match relevant research findings and data on resident care.

[2] Examples: (1) CMS should require a review of survey teams and specific survey findings when a team has conducted a survey with a 15% or higher rate of off-label antipsychotic drugging and has not cited for a drugging related F-Tag at a level of harm or above; (2) CMS and the states should conduct analyses of the 2567s (Statements of Deficiencies) for language that may indicate serious harm occurred but for which there is no finding of harm. For instance, repeating of the word "falls" in a 2567 with no harm citation should trigger a review and consultation with surveyor and surveyor team to make an assessment of the appropriateness of the citation.

a. *Identify & Implement Short and Long Term Goals*. Given the scope of this recommendation, we understand that it will – and should be – an ongoing process. However, we recommend that CMS identify both short and long term areas for improvement in performance review and implement improvements as they are identified.

b. *Establish a "Special Focus" Program for State Agencies.* In addition, CMS should focus on specific states for survey improvement efforts by implementing a "Special Focus SA Program" similar to the Special Focus Facility Program. These states, and the relevant Regional Offices (ROs), would receive increased guidance, as well as scrutiny, to improve practices.

2. Strengthen Survey Expectations, Guidance & Performance

i **Nursing Home "Never Events"** – Similar to CMS policy regarding hospital acquired conditions that should never occur (and which "when acquired in the hospital will no longer lead to higher Medicare payment"[3]), CMS should establish never events for nursing homes with public reporting requirements and, as appropriate, similar financial repercussions.

a. Never events are based on the National Quality Forum's identification of 28 "adverse events that are serious, largely preventable, and of concern to healthcare providers, consumers, and all stakeholders."[4]

b. Current never events that are highly applicable to nursing home resident care include: "Death/disability associated with use of device other than as intended,"

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[3] CMS, *Fact sheets: INCORPORATING SELECTED NATIONAL QUALITY FORUM AND NEVER EVENTS INTO MEDICARES LIST OF HOSPITAL-ACQUIRED CONDITIONS*, April 2008 (accessed at http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2008-Fact-Sheets-Items/2008-04-142.html). Hereinafter CMS 2008 Fact Sheet.

[4] National Quality Forum, Serious Reportable Events in Healthcare, 2006 Update (accessed at http://www.qualityforum.org/Publications/2007/03/Serious_Reportable_Events_in_Healthcare%E2%80%932006_Update.aspx). Note: There were originally 27 adverse events identified in 2002; the 28th adverse event was added later.

"Death/disability due to patient elopement," "Death/disability associated with medication error" and "Stage 3 or 4 pressure ulcers after admission."[5]

ii **Demonstrable Compliance** - Nursing homes should have to demonstrate compliance whenever a serious problem is likely to have occurred, such as a "never event," unanticipated hospitalization or death of a resident, identification of a resident care deficiency related to inadequate staffing (or in which an absence of sufficient staff is evident or suspected).[6]

iii **Use the Data** - CMS and states should make better use of data on resident care, outcomes, facility staffing, etc… to audit performance, pinpoint potential problems and substantiate violations.

a. As documented by *The New York Times*,[7] the nursing home industry is becoming increasingly sophisticated in gaming the system and, particularly as a result of the growth of for-profit and chain owned facilities, is likely to continue to do so.
b. CMS and the states have failed to either keep up with these developments or adapt to them effectively.
c. CMS should comply with unimplemented provisions of the ACA, including collecting staffing data from payroll records and reporting nursing homes' costs for nursing and other direct care, as well as indirect care, capital and administrative expenditures.
d. Performance, outcome and expense data should be used on a regular and consistent basis by the states, the Regional Offices and CMS Central Office to identify potential deficiencies and assist compliance efforts.

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[5] CMS 2008 Fact Sheet.

[6] For example, in terms of staffing, when a facility has a citation in which inadequate staffing is implicated, such as resident falls or serious pressure ulcers, the facility should be asked to demonstrate how it is ensuring sufficient staff to meet the needs of its residents and, if it fails to do so, face a citation at an appropriate level of scope and severity.

[7] Thomas, Katie, *Medicare Star Ratings Allow Nursing Homes to Game the System*, August 24, 2014 (Accessed at http://www.nytimes.com/2014/08/25/business/medicare-star-ratings-allow-nursing-homes-to-game-the-system.html).

e. CMS and the states should improve the quality of data reported by, and collected from, nursing homes based on identified shortcomings in those data and factors inhibiting their usefulness in assuring quality.[8]

iv **Clear and Strong Guidelines** – While there are numerous worthwhile components of existing *surveyor guidance*, the persistent and widespread failure to appropriately identify and rate deficiencies nationwide calls for greater clarity and *concrete guidelines* for surveyors, particularly for the appropriate rating of scope and severity. Thus, we call on CMS to promulgate basic guidelines for surveyors, comparable to those that exist in the federal sentencing guidelines system. This would not only help surveyors properly rate deficiencies; by curtailing fluidity of surveyor findings it would provide a means for more efficient substantiation and more consistent results.

v **Informal Dispute Resolution (IDR)** –

a. In cases stemming from a complaint, hearings should be open to allow a complainant or a complainant's representative to participate. In cases stemming from a survey, representatives from both the Resident and Family Councils should be invited to participate.

b. Complainants should have the equivalent right as facilities to call their own IDR when they disagree with a ruling, citation of deficiency, or lack of a citation of deficiency. To only provide the IDR option to facilities sends a clear signal to the entire nursing home community (including residents, workers, administration and, importantly, the surveyors themselves) that the fairness and efficacy of the survey process is centered on the facility and its needs and resources, rather than on the needs of the residents (for whom, presumably, the entire system exists) and the provision of care and quality of life services that meet (or exceed) minimum standards.

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[8] This is in addition to the needed improvements to Nursing Home Compare discussed below. For instance, CMS could implement and enforce changes to the cost reports (CMS Form 2540-10) required by the ACA to make the reported information more useful to the agencies' (and stakeholders') efforts to assess provider performance and appropriate uses of public funds.

c. The outcome of the IDR and the basis for that outcome should be disclosed in a public report (redacted, if necessary, to protect individuals' privacy). This must include any modification in the outcome that occurs outside of the IDR process, for instance by state agency leadership or other state officials.

d. Employees of nursing homes or individuals holding a financial or other interest in nursing homes should not be permitted to serve on an independent IDR.

e. Individuals whose complaints are resolved by an independent IDR should receive a report on the outcome and the reasons for any decision to overturn a survey finding.

vi **Address the Quality of Life/Quality of Care Differential** –

a. Our observations, experience and knowledge all indicate that, in practice, health care issues remain the primary focus of enforcement while quality of life and residents' rights are enforced to a much lesser extent, or not at all. Quality of life, autonomy and dignity are valid needs for which there exist numerous important standards in federal law and regulation. In addition to being important on their own, they are key to an individual's medical and physical health.

b. CMS should take concrete steps to ensure that the guidelines relating to resident dignity and quality of life promulgated in 2009 are effectuated. As CMS staff has noted, these are longstanding requirements, stemming from the 1987 Nursing Home Reform Law. In addition, in the quarter century since the Reform Law passed, our society has evolved in its recognition that individuals have the right to autonomy, dignity and a good quality of life no matter where they get care, irrespective of their age or ability. In short, the meaningful enforcement of dignity and quality of life standards is essential and long overdue.

vii **Clarify and Enhance Rights of Resident & Family Councils** –

a. *Federal Requirements*. Federal regulations (42 CFR 483) state: "When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility."

b. *Consumer Experience*. It is the experience of many consumers that this regulation is rarely enforced and, when it is, family and resident council complaints are not rated at a level higher than D or E.[9] Thus, functionally, CMS's position seems to be that while Resident and Family Councils have the right to *express* grievances and make recommendations concerning proposed policies and operational decisions affecting resident care and life in the facility, they should not expect that doing so will have a *meaningful impact* on their (or their loved ones') care.

viii **Correct Other Serious Functional and Systemic Biases** –

a. *Appeal Rights*. Consumers, including Resident and Family Councils, should be able to appeal survey results (for the same reasons stated above, re. IDR).

b. *Credibility*. Family, residents and LTC ombudsmen should be accorded the same credibility as staff.

c. *Detection of Falsification of Medical Records*. It is critical to improve both methodology and practice to ensure better investigation, detection and accountability for false entries on treatment and medication sign-off sheets and other resident records filled out by nursing home staff. Specific recommendations include: (1) Adopt methodology used by successful Medicaid Fraud Control Units and other state/federal program integrity agencies; (2) Require facilities where falsification or related fraud has been found to adopt facility-wide measures to prevent fraud such as the use of electronic medical records that allow for time tracking; (3) Require meaningful penalties for falsification of records, including significant financial penalties for relevant supervisory staff, administrators and owners.

Such penalties are critical in order to address the pervasive and serious problem of record falsification. They are appropriate under the longstanding legal doctrine of

[9] When a deficiency is identified in a nursing home the surveyor determines the level (severity) of harm to the resident or resident(s) involved and the scope of the problem within the nursing home. The surveyor then assigns an alphabetical "scope and severity" value to the deficiency ranging from "A" to "L." "A" is the least serious and "L" is the most serious rating. The levels of "D" and "E" (or below), as discussed here, indicate that, as far as the survey system is concerned, "no actual harm" occurred.

respondeat superior, which provides that an employer is responsible for the actions of employees performed within the course of their employment.[10]

3. Improve Quality & Quantity of Survey Staff – State Agencies & CMS Regional Offices

i **Training** - Surveyors should be well trained in both state and federal regulations and in the *meaning* and *purpose* of the laws and regulations: to protect residents and ensure that each is provided good care and quality of life in the facility.

ii **Team Makeup** - Improve makeup of survey staff and teams:

a. State survey agencies (SAs) should be strongly encouraged to utilize permanently employed surveyors with minimum reliance on contract surveyors. To accomplish this, CMS should develop thresholds for expected percentages of permanent SA survey staff and require states to provide an annual report on their survey staffing, whether or not they have met the threshold and, if not, report reasons why and steps they plan to take to improve. This report should assess reasons for turnover of surveyors and include efforts to increase surveyor retention. It should be posted on the state's website.

b. All survey teams should be multi-disciplinary: include persons with a social work background (in addition to those with a nursing background) and encourage employment of persons with advocacy training or background (i.e., a former ombudsman or consumer advocate).

c. All surveyors should be familiar with current quality of life and quality of care practices and standards.

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[10] Wikipedia provides a simple and straight-forward definition of *respondeat superior*: "Employer/employee relationships are the most common area wherein respondeat superior is applied, but the doctrine is also used in the agency relationship. In this relationship, the principal becomes liable for the actions of the agent, even if the principal did not directly commit the act. There are three considerations generally: (1) Was the act committed within the time and space limits of the agency?; (2) Was the offense incidental to, or of the same general nature as, the responsibilities the agent is authorized to perform?; (3) Was the agent motivated to any degree to benefit the principal by committing the act? The degree to which these are answered in the affirmative dictates the degree to which the doctrine can be applied." (Accessed at http://en.wikipedia.org/wiki/Respondeat_superior.)

B. IMPROVE PUBLIC INFORMATION ON NURSING HOME QUALITY & SAFETY

Following passage of the Affordable Care Act in 2010, the Coalition for Quality Care called on CMS to implement the Nursing Home Compare provisions "as quickly as possible." While some progress has been made, a number of significant requirements remain unfulfilled. As a result, this important resource falls far short of what the public needs and expects and, in critical ways, provides information that is so suspect that it constitutes a significant disservice to residents and families across the country. In addition, given especially the increasing sophistication and corporatization of the nursing home industry, further improvements are needed now more than ever. Simply put, until substantial improvements are implemented, residents and families do not have a fighting chance to get an accurate picture of the quality of nursing homes in their communities.

These improvements, such as the posting of accurate staffing data, resident census and hours of care provided per resident per day; information on staff turnover and tenure; information on number, type, severity and outcome of substantiated complaints; data on facility expenditures for nursing staff, as well as their expenditures for other direct care staff, indirect care, capital, and administrative costs; information on civil money penalties; and links to state websites with links to state inspection reports and facility responses/plans of correction, will be extremely valuable for consumers as they make critical decisions about their care.

Specific Recommendations:

1. Improve Staffing Information on Nursing Home Compare

- **Publish Staffing Based on Payroll Data** – The Affordable Care Act required that CMS post data based on actual payroll records because the self-reported (and unaudited) data currently published on CMS are widely-acknowledged to be (generally speaking) inflated. CMS should take immediate steps to implement a system that is as accurate as possible. In addition to being based on payroll data, CMS should take meaningful steps to ensure that these data reflect staffing levels of those individuals who are truly providing resident care. In order to effectuate this, CMS should conduct ongoing audits of providers and impose meaningful penalties when fraudulent reporting is uncovered.

ii **Publish Other Relevant Data on Staffing** – CMS should post information on staff turnover rates and tenure and take steps to accurately capture and publish information on consistent staffing.

iii **Realign Staffing Star Ratings** – The current paradigm for assigning staffing stars is based on a misleading interpretation of a 2001 CMS study, *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*.[11] That study found that 4.1 combined hours of licensed nurse and nursing assistant care was adequate to avoid harm, but CMS uses it to assign 5 stars—the highest quality rating. Facilities reporting 4.1 hours of nursing care should be assigned 3 stars for nurse staffing. It is important to note in this regard that the 2001 study focused on staffing levels necessary to achieve certain *health* outcomes. Staffing levels necessary to achieving other critical, federally mandated outcomes, such as those relating to *resident dignity* and *quality of life,* were, by and large, not considered.

2. Improve Other Information on Nursing Home Compare

i **Quality Measures** – Quality Measures should be based on accurate and audited data and the Quality Measure component of the Five-Star Rating System should be based upon quality measures with the most relevant, and most verifiable, data. Too often we see poorly performing nursing homes with four and five star ratings for quality measures. The result is a significant disservice to residents, families and other stakeholders who depend on CMS's website for accurate information. CMS should take steps to ensure that all quality measure data are valid and, in the short term, use only verifiable quality measures in the calculation of the Quality Measure component of the Five Star System.

ii **Sanctions Against Nursing Homes** –

a. Nursing Home Compare should publish the amount of all state as well as federal penalties, including any reductions in the amount of fines.

[11] Abt Associates Inc., *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Report to Congress: Phase II Final, Volume I (December 24, 2001). The report is available at www.allhealth.org.

b. CMS should publish all other enforcement actions taken against facilities. Consumers and the public have the right to complete information regarding sanctions against the nursing homes in their communities.

c. Enforcement actions should be available for at least five years on data.medicare.gov. Minimally, the database should include complete information for the last three calendar years (not the last three years on a rolling basis).

iii **Complaints Against Nursing Homes** – CMS should publish all complaints made to both the survey agencies and long term care ombudsman programs against nursing homes and the outcomes of those complaints.

iv **Ownership Information** – CMS should publish more robust ownership information for nursing homes in accordance with the requirements in the Affordable Care Act and to enable the public to easily identify all nursing homes owned by an individual, corporation or other entity. In addition, facilities that report inaccurate, incomplete or misleading ownership information should be sanctioned.

v **Statements of Deficiencies (SODs)** – CMS should cease redacting portions of the SODs that do not identify individual residents, for instance the names of drugs and medical conditions. This information (i.e., unredacted SODs) is already available through different avenues, such as the ProPublica website and many states' websites. The public has the right to this (often crucial) information on the principal – and most robust – resource on nursing home quality, Nursing Home Compare.

C. ADDITIONAL RECOMMENDATIONS TO IMPROVE QUALITY & RESTORE CONFIDENCE

1. Use of Civil Money Penalties (CMPs)

i **Ensure Implementation of Federal Law** –

a. Regional office (RO) personnel should have training and resources necessary to ensure that states' uses of CMPs follow federal requirements. In particular, ROs must be held accountable for ensuring that CMPs are not given to nursing homes to

provide services or achieve standards for which they are already being paid. CMP funds are typically the result of significant neglect, abuse or other harm perpetrated on residents as a result of egregious facility deficiencies. To give penalty money back to facilities to help them achieve minimum standards is not only a form of legitimized fraud, it is also a slap in the face to the residents and families who have suffered, and sometimes died, as result of a facility's failure to meet these standards.

"To give penalty money back to facilities to help them achieve minimum standards is not only a form of legitimized fraud, it is also a slap in the face to the residents and families who have suffered."

b. CMS should interpret these CMP constraints carefully and conservatively to ensure that only projects that are clearly beyond the scope of required services and standards are funded.
c. In addition to holding RO staff accountable, CMS should hold states accountable and require the return of any CMP funds that were not used appropriately.
d. CMS and the states should publish on their websites the approved uses of the funds, including the approved proposals, reports on outcomes, all products (which should be freely available to the public) and an annual accounting of CMPs collected by the states, how much money was distributed and how much remains in state CMP accounts.

2. Focus CMS Resources on Core Activities

i **Less QAPI, More QA** – As residents and resident advocates, we applaud nursing homes that undertake activities to improve care. However, for reasons noted earlier, we are very troubled by quality improvement efforts that incorporate CMS and state survey agencies. With the existence of widespread and preventable harm to nursing home residents, coupled with the persistent failure on the parts of CMS and the states to hold providers accountable for compliance, it is hard to understand why CMS is dedicating staff time and resources to internal facility processes and trainings rather than toward better fulfilling its core mission to protect residents and enforce the Nursing Home Reform Law.

ii **Less Goal-Setting, More Action** – While we were initially encouraged by CMS's dedication to improving the scandalous rates of inappropriate antipsychotic drug use in nursing homes, we are now deeply concerned that failure to match enforcement with the rhetoric in the national campaign to improve dementia care and reduce drugging has resulted in far too many residents being chemically restrained illegally and with impunity. CMS should stop dedicating state and federal survey and enforcement resources to trainings and other activities to encourage provider compliance with longstanding requirements, and it should take substantive steps to hold providers accountable.

IV. Appendix: Members of CQC

Alabama - Alabama Advocates for Quality Care

Arkansas - Arkansas Advocates for Nursing Home Residents

California - California Advocates for Nursing Home Reform

District of Columbia - Voices for Quality Care

Florida - Advocates Committed to Improving Our Nursing Homes

Florida - Families for Better Care

Illinois - Nursing Home Monitors

Indiana - United Senior Action

Kansas - Kansas Advocates for Better Care

Kentucky - Kentuckians for Nursing Home Reform

Maryland - Voices for Quality Care

Massachusetts - Cape United Elders of Community Action Committee

Massachusetts - Massachusetts Advocates for Nursing Home Reform

Minnesota - ElderCare Rights Alliance

New York - Coalition of Institutionalized Aged and Disabled

New York - Long Term Care Community Coalition

Texas - Texas Advocates for Nursing Home Residents