Improving the Quality of Care in Nursing Homes

Committee on Nursing Home Regulation
Institute of Medicine

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THE ORIGINAL 1986 IOM STUDY WHICH RESULTED IN THE OBRA '87 NURSING HOME REFORM ACT AND TODAY'S SURVEY AND ENFORCEMENT SYSTEM.

Committee on Nursing Home Regulation

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Introduction and Summary

PURPOSE OF THE STUDY

This is the report of a study of government regulation of nursing homes (excluding intermediate care facilities for the mentally retarded). The study's purpose was to recommend changes in regulatory policies and procedures to enhance the ability of the regulatory system to assure that nursing home residents receive satisfactory care.

In May 1982, the Health Care Financing Administration (HCFA) announced a proposal to change some of the regulations governing the process of certifying the eligibility of nursing homes to receive payment under the Medicare and Medicaid programs. The changes were responsive to providers' complaints about the unreasonable rigidity of some of the requirements. The proposed changes would have eased the annual inspection and certification requirements for facilities with a good record of compliance, and would have authorized states, if they so wished, to accept accreditation of nursing homes by the Joint Commission on Accreditation of Hospitals (JCAH) in lieu of state inspection as a basis for certifying that Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs) are in compliance with

the federal conditions of participation and operating standards.

The HCFA proposal was strongly opposed by consumer groups and most state regulatory agencies because the proposed changes were seen as a movement in the wrong direction--that is, towards easing the stringency of nursing home regulation--and because they did not deal with the fundamental weaknesses of the regulatory system. The controversy generated by the proposal caused Congress in the fall of 1982 to order the HCFA to defer implementing the proposed changes until August 1983 and ultimately resulted in a HCFA request to the Institute of Medicine (IOM) of the National Academy of Sciences to undertake this study. The contract between the HCFA and the IOM became effective on October 1, 1983. The charge to the IOM Committee on Nursing Home Regulation was to undertake a study that would "serve as a basis for adjusting federal (and state) policies and regulations governing the certification of nursing homes so as to make those policies and regulations as appropriate and effective as possible."[1]

THE PUBLIC POLICY CONTEXT OF THE STUDY

There is broad consensus that government regulation of nursing homes, as it now functions, is not satisfactory because it allows too many marginal or substandard nursing homes to continue in operation. The implicit goal of the regulatory system is to ensure that any person requiring nursing home care be able to enter any certified nursing home and receive appropriate care, be treated with courtesy, and enjoy continued civil and legal rights. This happens in many nursing homes in all parts of the country. But in many other government-certified nursing homes, individuals who are admitted receive very inadequate--sometimes shockingly deficient--care that is likely to hasten the deterioration of their physical, mental, and emotional health. They also are likely to have their rights ignored or violated, and may even be

subject to physical abuse. The apparent inability of the current regulatory system either to force substandard facilities to improve their performance or to eliminate them is the underlying circumstance that prompted this study.

In the past 15 years many studies of nursing home care have identified both grossly inadequate care and abuse of residents.[2-23] Most of the studies revealing substantial evidence of appallingly bad care in most parts of the country have dealt with conditions during the 1970s. However, testimony in public meetings conducted by the committee in September 1984, news reports published during the past 2 years, recent state studies of nursing homes, and committee-conducted case studies of selected state programs have established that the problems identified earlier continue to exist in some facilities: neglect and abuse leading to premature death, permanent injury, increased disability, and unnecessary fear and suffering on the part of residents. Although the incidence of neglect and abuse is difficult to quantify, the collective judgment of informed observers, including members of the committee and of resident advocacy organizations, is that these disturbing practices now occur less frequently.

Residents and resident advocates, both in public hearings and in a study of resident attitudes conducted by the National Citizens' Coalition for Nursing Home Reform,[24] expressed particular concern about the poor quality of life in many nursing homes. Residents are often treated with disrespect; they are frequently denied any choices of food, of roommates, of the time they rise and go to sleep, of their activities, of the clothes they wear, and of when and where they may visit with family and friends. These problems may seem at first to be less urgent than outright neglect, but when considered in the context of a permanent and final living situation they are equally unacceptable.

The quality of medical and nursing care in many homes also leaves much to be desired. Geriatrics is becoming, in the mid-1980s, an area of concentration within internal

First, under present circumstances, a free market for nursing home care will remain a theoretical concept until such time, if ever, that a major portion of the financing of long-term care services has shifted from public sources (primarily Medicaid) to private insurance. This is not likely to occur very soon. About half of current nursing home revenues come from appropriated state and federal funds through state-controlled Medicaid programs. Most people enter nursing homes as private-pay residents and soon "spend down" their income and assets until they become eligible for Medicaid. With few exceptions, community-based or home-based long-term care services--that might keep some people who require long-term care from entering nursing homes--are not eligible for Medicaid or other sources of public support. Most states maintain tight control on bed supply to control growth of their Medicaid budgets. They have learned that if they allow uncontrolled growth of nursing home beds, the additional beds would quickly be filled with residents now being cared for privately and informally in the community. Such residents would initially be private-pay, but would soon "spend down" to Medicaid eligibility.

Second, historical experience hardly supports an optimistic judgment about the effects on quality of care of allowing market forces, to exert the primary influence over nursing home behavior. Nursing homes were essentially unregulated in most states prior to the late 1960s. Their operations were governed almost entirely by market forces, and the quality of care was appalling. (See Appendix A.)

Persons needing nursing home care generally suffer from a large array of physical, functional, and mental disabilities. A significant proportion of all residents are mentally impaired. The average resident's ability to chose rationally among providers and to switch from one provider to another is therefore very limited even if bed occupancy rates are low enough to make such choices feasible. But they are not. In most communities, bed availability is the controlling factor because occupancy rates are very high. Moreover, some who reside in nursing homes lack close family to act as their advocates. Even

medicine, family medicine, and psychiatry. (Both the American Academy of Family Practice and the Board of Internal Medicine have decided to establish certificates recognizing geriatric competence.) Many conditions that were once accepted as inevitable consequences of old age now can be treated or alleviated. Physicians and nurses in nursing homes are not always aware of advances in geriatrics so that even in pleasant and humane institutions examples may be found of residents whose disability could be reduced, whose pain could be controlled, or whose depression could be treated if they received proper medical care. A lower standard of medical and nursing practice should not be accepted for nursing home residents than is accepted for the elderly in the community. Given the fragility of nursing home residents and their dependence on medical care for a satisfactory life, practice standards should even be higher. Thus, physicians, as well as nurses, have substantial responsibility for quality of care in nursing homes.

These observations do not mean that the picture of American nursing homes is entirely gloomy or that the regulatory efforts of the past decade have been entirely unsuccessful. Today, many institutions consistently deliver excellent care. Good care can be observed in all parts of the country; it exists under widely varying reimbursement systems and all types of ownership. Such facilities serve both as evidence that overall performance can be improved and as markers for how that improvement can be accomplished.

The question asked by the committee was: How can the problems observed in nursing homes in the 1980s best be addressed? The current national tone is antiregulatory. Nursing homes are a service industry. Could not the observed problems be solved by decreasing regulation and allowing market forces to work? This viewpoint was advocated by some who spoke at public meetings or submitted ideas to the committee. Those who wished to see a freer market were particularly anxious to have restrictions on bed supply lifted.

A freer market was not considered by the committee to be a serious alternative to more effective government regulation for two reasons.

if they have family, the choice of a nursing home is usually made relatively hastily in response to a new illness or disability level; once in an institution, the opportunities for transfer to another nursing home are very limited.[26]

The difficulties inherent in choosing among nursing homes are further exacerbated by the financial status of many residents. Because of the cost, few individuals or families can afford a prolonged nursing home stay.[26] As a result, government programs, primarily Medicaid, assist in paying for more than 60 percent of all care. In most states, Medicaid rates are lower than those paid by private residents. As a result the nursing home market is, in fact two markets--a preferential one for those who can pay their way and a second, more restricted one, for those whose stays are paid by Medicaid.[27]

Regulation is essential to protect these vulnerable consumers. Although regulation alone is not sufficient to achieve high-quality care, easing or relaxing regulation is inappropriate under current circumstances.

The federal regulations now governing the certification of nursing homes under the Medicare and Medicaid programs have been in place, essentially unchanged, since the mid-1970s. Their central purpose is to assure that nursing home residents[28] receive adequate care in a safe facility and that they are not deprived of their civil rights. The regulations have a number of conceptual and technical weaknesses that were recognized almost from the time the regulations were promulgated. And, the regulations are administered and enforced very unevenly by the states. Yet there is consensus that regulations have made a positive contribution, although reliable comparative data are not available to support this judgment. The committee found that the consumer advocates, providers, and state regulators with whom it discussed these matters believe that a larger proportion of the nursing homes today are safer and cleaner, and the quality of care, on the average, probably is better than was the case prior to 1974. But there is substantial room for improvement.

Providers, consumer advocates, and government regulators all are dissatisfied with specific aspects of the

regulations and the way they are administered.[29] Consumer advocates (nursing home residents, their families, and representatives of organizations concerned with protecting the interests of nursing home residents) contend that the standards are inadequate and their enforcement is too lax because too many nursing homes that pass inspection still provide unacceptably poor or only marginally adequate care. Moreover, they contend that violations of residents' rights occur in many homes and that often such violations either are not detected or are ignored by the regulatory authorities. The providers (nursing home operators, administrators, and professional staff) are concerned with the excessive attention to detailed documentation, the emphasis on structural specificity with the inherent (and sometimes irrational and costly) inflexibility that such specificity implies, and with the ambiguity of some of the standards (for example, the use of such words as "adequate") that result in inconsistent, subjective interpretations by state and federal surveyors. Some government regulators at both state and federal levels believe there is merit in both sets of contentions.

Since the present regulatory framework was set in place about 10 years ago, there have been developments that make possible a more effective regulatory system. There is deeper understanding of what is meant by high-quality care for nursing home residents and how to provide it, more knowledge of how to assess quality of care objectively, and better understanding of what it takes to operate a more effective quality assurance system. The nursing home industry itself has grown in managerial capability and professionalism. These developments make it possible now to redesign the regulatory system so that it will be much more likely to assure that all nursing homes provide care of acceptable quality.

Actions Taken

Federal Nursing Home Reform Act Creates National Standards for Nursing Homes

With more than 3 million Americans living in more than 15,000 nursing homes each year, providing quality care in these institutions is imperative. The 1986 IOM report *Improving the Quality of Care in Nursing Homes* had a dramatic effect on the care provided in nursing homes. Almost immediately, the report's recommendations were translated into the Federal Nursing Home Reform Act, for the first time creating national standards of care and rights for people living in nursing homes.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ADVERSE EVENTS IN SKILLED NURSING FACILITIES: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES

Daniel R. Levinson
Inspector General

February 2014
OEI-06-11-00370

EXECUTIVE SUMMARY: Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries
OEI-06-11-00370

WHY WE DID THIS STUDY
From 2008–2012, we conducted a series of studies about hospital adverse events, defined as harm resulting from medical care. This work included a Congressionally mandated study to determine a national incidence rate for adverse events in hospitals. As part of this work, we developed methods to identify adverse events, determine the extent to which events are preventable, and measure the cost of events to the Medicare program. This study continues that work by evaluating post-acute care provided in skilled nursing facilities (SNF). SNF post-acute care is intended to help beneficiaries improve health and functioning following a hospitalization and is second only to hospital care among inpatient costs to Medicare. Although various health care stakeholders have in recent years paid substantial attention to patient safety in hospitals, less is known about resident safety in SNFs.

HOW WE DID THIS STUDY
This study estimates the national incidence rate, preventability, and cost of adverse events in SNFs by using a two-stage medical record review to identify events for a sample of 653 Medicare beneficiaries discharged from hospitals to SNFs for post-acute care. Sample beneficiaries had SNF stays of 35 days or less.

WHAT WE FOUND
An estimated 22 percent of Medicare beneficiaries experienced adverse events during their SNF stays. An additional 11 percent of Medicare beneficiaries experienced temporary harm events during their SNF stays. Physician reviewers determined that 59 percent of these adverse events and temporary harm events were clearly or likely preventable. They attributed much of the preventable harm to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care. Over half of the residents who experienced harm returned to a hospital for treatment, with an estimated cost to Medicare of $208 million in August 2011. This equates to $2.8 billion spent on hospital treatment for harm caused in SNFs in FY 2011.

WHAT WE RECOMMEND
Because many of the events that we identified were preventable, our study confirms the need and opportunity for SNFs to significantly reduce the incidence of resident harm events. Therefore, we recommend that the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) raise awareness of nursing home safety and seek to reduce resident harm through methods used to promote hospital safety efforts. This would include collaborating to create and promote a list of potential nursing home events—including events we found that are not commonly associated with SNF care—to help nursing home staff better recognize harm. CMS should also instruct State agency surveyors to review nursing home practices for identifying and reducing adverse events. AHRQ and CMS concurred with our recommendations.

Adverse Events in Skilled Nursing Facilities: LeadingAge Response to OIG Report

by Dr. Cheryl Phillips
Published On: Feb 27, 2014

On March 3, the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) released Adverse Events in Skilled Nursing Facilities, a study evaluating adverse events in skilled nursing facilities. The OIG's conclusions? A little over 1 in 5 (22%) short stay residents experienced an adverse event and another 11% experienced a temporary harm event. Roughly two-thirds (59%) were deemed preventable.

Yes, the data sample was small, given the large number of admissions to SNFs for post acute care; and yes, there was possibly selection bias, given the presumed limited geographic distribution of the sample cases. But, either way you look at it, if this is you or your loved one, a bad event is a bad thing.

Shifting Our Focus to Resident Safety

Let's look back at the Institute of Medicine report of 2001, Crossing the Quality Chasm, which took a hard look at adverse events and negative outcomes that occur in the health care system. Out of this study came the Institute for Healthcare Improvement's 100,000 lives campaign.

Both the 2001 IOM report and the IHI campaign focused on developing a "culture of safety." Relying on work environments based on fear and punishment merely drives the high-risk behaviors of the work force "into the dark." When people are afraid, they don't risk sharing negative events and "near misses," data cannot be collected to identify trends, and others cannot learn from those mistakes.

IOM's 6 Recommendations

The IOM study provided 6 primary recommendations, including:

- The idea that care should be "person-centered with patients as the source of control."
- That there should be shared knowledge of information between clinicians and patients.
- That care should be driven by evidenced-based procedures.
- That safety should be woven into the fabric of the culture with transparency as the starting point.

It is easy to get defensive about this nursing home report. My own initial reaction was to challenge the data and the sample size, to try to push back that "these residents are so complex in their care," and to focus on the findings that 1/3 were found to be "not preventable."

And, I can tell you this is exactly how the hospitals and physicians reacted to the IOM study about medical care and the estimated 100,000 lives lost each year to medical errors. But, the more time we spend defending our current state of care, the longer it takes us to move towards solutions.

OIG's Recommendations

I concur with the OIG's recommendations to develop Patient Safety Organizations, where tracking safety-related events can occur without the hammer of punishment and citation. Without such it is virtually impossible to create that transparent environment of self-reporting that is necessary in a safety culture.

I also agree that we need better evidence for best-practice care in this very high risk and vulnerable population. Most studies for treatments are done in younger adults and rarely in the nursing home setting.

However, I disagree with the report that looks to surveyors to "reduce adverse events." We have yet to see evidence that a punitive oversight process, that is built on fines and punishment, as a driver of excellence and safety. We need surveys to ensure compliance with regulations. We need a safety culture to transform care.

Wouldn't it be remarkable if we could get an IOM study to look at the survey and certification process in nursing homes?

Is this system of regulation really driving excellence, and if not, how might it be improved? We need standards to define a "floor" of care and we need a person-centered culture that creates an environment of quality, excellence and safety.

If the OIG, AHRQ and the Centers for Medicare and Medicaid Services (CMS) are serious about these findings, we will mirror systems of care changes that occurred in the hospital. We have a wealth of resources available to us.

Many of our members are already recognized leaders in quality. We are active members and partners in Advancing Excellence in America's Nursing Homes, probably the best example of a public-private partnership to improve care in nursing homes.

And, many of our state leaders work closely with the Quality Improvement Organizations and the Local Area Networks for Excellence (LANE).

But this is not enough.

Each provider organization must look closely at their own "culture of quality and safety." It starts from the organizational leadership and weaves through the entire community. By integrating into our daily work the principles of the QAPI framework, we at LeadingAge, can be some of the leaders in this transformation.

State of Wisconsin
Department of Health and Family Services

Scott McCallum, Governor
Phyllis J. Dubé, Secretary

CMS DENIES: CLAIMS ONLY
CONGRESS HAS THIS AUTHORITY;
WE WISH TO CODIFY THAT

April 4, 2002

The Honorable Tommy G. Thompson
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

Dear Secretary Thompson:

The State of Wisconsin requests authorization to pilot a modified nursing home survey process. We are making this request pursuant to section 1115 of Public Law 92-603. This law provides broad authority to the Secretary of Health and Human Services to allow for demonstrations, experiments, and pilot projects in efforts to resolve major health care financing issues and to develop innovative methods for the administration of Medicare and Medicaid. The current survey process limits states' ability to allocate necessary resources to nursing homes experiencing significant problems. Our proposal allows Wisconsin the flexibility needed to improve the quality of care and quality of life for vulnerable nursing home residents to a greater extent than we are presently able to do.

Wisconsin's pilot proposal has been developed collaboratively among the Wisconsin Department of Health and Family Services, nursing home representatives, and resident advocates. It uses the entire framework of the existing nursing home survey process, as required by the Centers for Medicare and Medicaid Services, but tailors the length and depth of the survey to the individual facility. Some facilities will experience no change in the current survey process. Others will experience either directed or a more intensive survey, depending upon the facility's history and the problems that are identified during the initial phase of the survey. This proposal does not change the frequency of nursing home surveys, all Wisconsin nursing homes continue to be surveyed annually.

Our proposal retains the focus upon quality of care, quality of life, and resident rights. At the same time, it offers flexibility to the state survey agency, allowing it to target limited state survey agency staff for facilities experiencing more significant problems than their peers. It will also allow the survey agency to assist noncompliant facilities to come into compliance, ultimately improving quality of care and quality of life, through the provision of limited technical assistance and the sharing of "best practice" guidelines.

Wisconsin will continue to survey for recertification all nursing homes within the present 9-15 month interval, maintaining a 12-month average as required by federal law. Each survey, at a minimum, will include the required elements outlined in Title XVIII of the Social Security Act, section 1819(g)(2)(a)(ii). Specifically, each survey will include a case-mix stratified sample of residents that evaluates:

- 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;

- written plans of care and an audit or resident assessments to determine the accuracy and adequacy of each; and
- residents' rights.

Our survey proposal will not modify or limit current regulations relating to federal enforcement actions. It will be used within the structure of the current survey process.

We propose piloting this survey process in the western region of the state, which encompasses approximately 90 nursing homes, or 21% of the certified nursing homes in Wisconsin. The pilot will continue for three years. We will evaluate the effectiveness of the pilot through a research team consisting of faculty and students from the University of Wisconsin (Eau Claire and Madison) and the University of Minnesota. Details concerning this evaluation are included in the final four pages of the attached proposal.

Thank you for reviewing our proposal. If you have additional questions, please contact Susan Schroeder, Director, Bureau of Quality Assurance/Department of Health and Family Services, at 608-267-7185. Wisconsin is ready and willing to work with the Department of Health and Human Services and the Centers for Medicare and Medicaid Services to improve the nursing home survey and certification process.

Sincerely,

Phyllis J. Dubé, Secretary
Department of Health and Social Services

George Potaracke, Executive Director
Wisconsin Board on Aging and Long Term Care

Susan Schroeder, Director
Bureau of Quality Assurance

John Sauer, Executive Director
Wisconsin Association of Homes and Services for the Aging

Tom Moore, Executive Director
Wisconsin Health Care Association

WISCONSIN
NURSE AIDE TRAINING PROGRAM
AND
REGISTRY MANUAL

STATE OF WISCONSIN
DEPARTMENT OF HEALTH SERVICES

Division of Quality Assurance
Office of Caregiver Quality

P-00118 (Rev. 01/11)

Issued December 2001
Revised September 2005
Revised December 2007
Revised November 2008
Revised January 2009
Revised April 2009

CHAPTER 2 NURSE AIDE TRAINING

2.1.0 INSTRUCTIONAL PROGRAMS

An instructional program is a training program for nurse aides (including those who work as home health and hospice aides) approved by the Department of Health Services (DHS), Division of Quality Assurance (DQA). The purpose of an instructional program is to provide a basic level of both knowledge and demonstrable skills for individuals who provide nursing or nursing-related services to residents in licensed health care facilities and who are not licensed health professionals or volunteers who provide services without monetary compensation.

In Wisconsin, all approved nurse aide training programs must provide students with comprehensive instruction on the requirements to work in all types of licensed health care facilities (e.g., nursing homes, home health agencies, hospices, hospitals, intermediate care facilities for persons with mental retardation). DQA approves nurse aide training programs that satisfy the standards outlined in s. 42 CFR 483.152 and Chapter DHS 129 of the Wisconsin Administrative Code.

DQA reviews the curriculum of each approved training program at least once every 24 months following the approval date to determine whether the program continues to satisfy the required standards. DQA may suspend or revoke the approval of a training program or impose a plan of correction on the program if the program does not satisfy the required standards or operates under conditions other than those contained in the approved application.

2.1.1 Prohibitions

Federal regulations prohibit DQA from approving a training program offered by or in a long term care facility if, in the 2 years prior to the application:

- A skilled nursing facility or a nursing facility has been subject to an extended or partial extended survey under federal regulations;
- A skilled nursing facility or a nursing facility has been subject to a federal civil money penalty of not less than $5,000;
- A skilled nursing facility or a nursing facility was terminated as a provider under Title 18 (Medicare) or under the State plan under Title 19 (Medicaid);
- A skilled nursing facility or a nursing facility had been subject to the penalty of denial of payment under Title 18 or Title 19;
- A skilled nursing facility or a nursing facility was subject to the penalty of an appointment of a temporary manager to oversee operations;
- A skilled nursing facility or a nursing facility was closed or had its residents transferred due to State action.
- A skilled nursing facility had a waiver of the requirement for a full time registered nurse employed 40 hours a week;
- A nursing facility had a waiver of the requirement for a registered nurse for at least 8 consecutive hours, 7 days a week;

2.1.2 Waivers of Federal Prohibitions

A long term care facility may request a waiver of the 2-year prohibition by writing to DQA, specifying the rule from which the waiver is requested and the time period for which it is requested, provided that the following conditions are met:

- There is no approved training program within a 45-mile or 60-minute radius from the facility requesting the waiver;
- The facility is an adequate training environment because the prohibitions were non resident/nursing care related;
- An approved training program unrelated to the facility has agreed to provide the training; and,
- The applicant has alerted the ombudsman of its waiver request.

Submit waiver requests to the:

Nurse Aide Training Consultant
Office of Caregiver Quality
P.O. Box 2969
Madison, WI 53701-2969

DQA will approve or deny each waiver request in writing within 45 days of receipt. DQA may modify the terms of a waiver request, impose other conditions, or limit the duration of a waiver that is approved.

Tom Ramsey

From: Hintze, Cynthia L - DHS [Cynthia.Hintze@dhs.wisconsin.gov]
Sent: Thursday, March 20, 2014 8:32 AM
To: Tom Ramsey
Cc: Arkens, Laurie J - DHS; Busse, Shari E - DHS
Subject: RE: CNA Training Programs

Mr. Ramsey,

Laurie Arkens has asked that I respond to your March 14th request regarding nurse aide training program prohibitions:

There are currently 118 Wisconsin nursing homes under a federal nurse aide training and competency program (NATCEP) prohibition.

Typically only those facilities that have served as a clinical site for a particular nurse aide training program are the ones who apply for the waivers. Those facilities who have not participated in training generally have not applied for a waiver.

NATCEP Waiver requests:

- In 2012, the Department received 6 waiver requests; 3 were approved and 3 were denied.
- In 2013, the Department received 4 waiver requests; 0 were approved and 4 were denied.
- To date in 2014, we have received 2 waivers; 1 was approved and 1 is currently under review.

Please see Chapter 2 of the Nurse Aide Training Program & Registry Manual at http://www.dhs.wisconsin.gov/caregiver/publications/NATDMan.htm for more information. Feel free to contact me if you have any other questions.

Thank you ~
Cindy

Cindy Hintze RN
Nurse Aide Training Consultant
Office of Caregiver Quality
P.O. Box 2969 Room 450
Madison, WI 53701
cynthia.hintze@wisconsin.gov
608-261-8328
608-264-6340 fax

Begin forwarded message:

> **From:** Tom Ramsey <tramsey@leadingagewi.org>
> **Date:** March 14, 2014 at 10:25:34 AM CDT
> **To:** "Arkens, Laurie J - DHS" <Laurie.Arkens@dhs.wisconsin.gov>
> **Subject: CNA Training Programs**
>
> Hi Laurie,

Tom Ramsey

From: Rachelle Valleskey [RValleskey@rockyknoll.net]
Sent: Friday, March 07, 2014 10:58 AM
To: Tom Ramsey
Subject: Prohibition of Nurse Aide training

Good morning Tom,

Rocky Knoll Health Care Center had its last annual survey conducted on 2/14/2013 which resulted in a recommendation to impose a two year Nurse Aide Training prohibition. Through the course of submitting an acceptable Plan of Correction, and undergoing a successful verification visit, our facility was deemed to be in substantial compliance. As a result, we thought the risks of Civil Money Penalty, Loss of funding for new admission, and Nurse Aide training prohibition should have been resolved.

CMS then issued a delayed response and imposed a Civil Money Penalty to our facility. The initial recommendation from the State was that $2,500 be charged. CMS chose to impose CMP of $15,750.00 with a 35% reduction if we waived our right to a hearing. We had corporate counsel review and the decision was made to waive our right to a hearing and paid the amount of $10,237.50 in full.

We then contacted the state agency, and requested a waiver of the Nurse Aide training Prohibition. That request was denied based on Rocky Knoll Health Care Center not meeting the requirements of Public Law 105-15 based on the following:

There are 5 approved training programs within a 45 mile radius of the Rocky Knoll Health Care Center. Although one of those programs (Lakeshore Technical College) indicated a desire to continue to utilize our facility as a clinical site, our facility does not meet the requirement that there are no other programs offered within a reasonable distance from the facility, therefore the waiver requirements could not be applied to Rocky Knoll Health Care Center.

Of note, our facility has been a preferred training site for Lakeshore Technical College's nurse aide training for many years. We have innovative classroom settings inclusive of simulated care settings, desks and computers for students. The instructors have commented that Rocky Knoll is their favorite skilled nursing facility to come to for training their students. Prior to receiving notification from CMS, LTC had scheduled multiple training sessions to occur on our campus. In a typical calendar year, we would host 5 to 6 training sessions.

Results of not being a host site are inclusive of damaged reputation in the community. Once word was out to the other facilities in Sheboygan County, that Rocky Knoll was not able to host nurse aide training, erroneous assumptions were made that we received an Immediate Jeopardy citation. It took quite a bit of communicating with the other sites, to squelch that rumor.

Additionally, our residents have suffered the loss of having the students in the building providing care and companionship. The students were always a nice addition to our scheduled staff, and allowed for the "extras" to happen due to more time and attention being able to be spent on the residents.

And finally, we have not been as successful in filling open nurse aide positions. We are utilizing excessive amounts of overtime to cover the needed hours of help. Not having students in the building has severely impacted our ability to offer employment to new nurse aides.

While we fully accept and recognize that our last annual survey identified deficiencies that needed to be corrected, we also feel that because the effort was put into correcting those areas, and also that we were penalized severely with Civil Money Penalty, that we have been sorely punished enough. The prohibition of nurse aide training does not improve our

quality, does not make us better in any way, and has a negative impact on our residents and our fiscal responsibility to the tax payers as we are a County owned facility.

Take great care,

Rachelle Valleskey, RNC, BSN, NHA
Nursing Home Administrator
Rocky Knoll Health Care Center
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Tom Ramsey

From: Pete Eide [peide@lacrossecounty.org]
Sent: Friday, March 07, 2014 9:16 AM
To: Tom Ramsey
Subject: Nurse Aide Training Programs: A Quick Question

Tom,
Hillview Health Care Center formally requested that a wavier be granted in 2011 to allow us to continue to offer Nurse Aide Training to the students of Western Wisconsin. It was denied

Background: Because an extremely small percentage (like 1%) of call lights allegedly were not working building, (we have about 350 call lights) we got an IJ. The handful of lights that did not work that were in rooms were a extremely demented resident person was in the could not and did understand the call light system to use. (we think a call light broke and staff just switched it the roommate who didn't use it instead of filling out a maintenance slip.) Because of this IJ our nurse aide training was been prohibited for two years.

I wrote a letter requesting a wavier that was denied by Cindy Hintze. We know this nurse aid training ban is and was a great hardship for the employees, residents and especially the students in the area, who will be our workforce someday. This IJ was considered a maintenance issue and is not nurse aide training related at all.

I am told by Western Technical College how pleased they are to be able to offer nurse aide training here at Hillview. I have been told they feel we have the best nursing home in the area and are able to take the most students. (We are the largest nursing home in the western part of the state.) We provided letters from Western Technical College in our support of continuing to be able to offer the training. One of the Western Tech College CNA instructors has worked for part time for us 8 years, I think that says a lot.

This is something I am willing to keep fighting for. This unfair and very punitive rule that really should not be part of the survey punishment process. We can still do training and internships for every other department after an IJ, including nurses, LPN, dietitians, rec therapy, administrator etc., etc.

This is a huge problem for nursing homes and the students who sometimes have to drive 45 minutes to a clinical site. The state needs to think about making cna training convenient accessible not put up barriers. Also we were able to hire a handful of the students to join our team so now we potentially have less staff too.

Then in 2012 we has a state survey with 12 citations all minor level d, however the feds came in for a follow up survey and added a few more and increased one to IJ because they are the feds. We won IDR against the feds but the feds have the unfair right to reject it and did. So cna training was banned again. The IJ Abuse reporting to the state by administration which also has very little to do with cna training.

Can you tell I am bitter about the survey process and punishment.?

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LeadingAge urges Congress to take the following actions on issues that matter to seniors and those who serve them:

Medicare and Medicaid

- Fix the "observation days" problem in Medicare - cosponsor HR 1179/S 569.
- Repeal Medicare therapy caps and replace with a medical review process, as under S. 1871.
- No more across-the-board Medicare cuts for skilled nursing facilities, home health care or hospice.
- No reductions in federal Medicaid funding to the states.

Senior housing under Section 202 and Section 8

- Fully fund 12-month renewals of all rental assistance contracts.
- Fund the Section 202 Supportive Housing for the Elderly demonstration for FY2015.
- Renew and award service coordinator grants.

Home- and community-based services

- Reauthorize the Older Americans Act.
- Fund OAA programs at levels sufficient to meet the needs of a growing elder population.

Quality

- Institutes of Medicine should examine the nursing home oversight system and recommend reforms.

Not-for-profit difference

- Preserve tax-exempt status for not-for-profit aging services providers and the income tax deduction for charitable donations by taxpayers at all income levels.
- Protect and stimulate investment in the low-income housing tax credit.

Financing long-term services and supports

- Continue the work begun by the Long-Term Care Commission to find a more sustainable, healthy and affordable means of financing long-term services and supports.