

**PREDICTING AND PREVENTING
NURSING HOME “PERFORMANCE
CLOSURES” IN MICHIGAN:
WHY REGULATORS MAY NOT HAVE
ALL THE TOOLS THEY NEED¹**

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Over a two-and-one-half-year period, the Michigan Department of Consumer Industry Services forced the closure of seven nursing homes and identified ten other facilities at risk of closure that eventually came into compliance with government regulations. In her study of these closures, Alison E. Hirschel analyzes why some

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were subject to more severe financial distress and physical plant deficiencies than the ones that remained open. However, numerous citations from government regulators do not correlate to closure. Ms. Hirschel proposes a change in state and federal enforcement policy to improve the ability of nursing home regulators to identify at risk facilities and to intervene more effectively.

I. Introduction

Between March 1998 and September 2000, the Michigan Department of Consumer and Industry Services (MDCIS), the state agency that licenses and regulates nursing homes, issued a notice of emergency license revocation to seven nursing homes, thus forcing the closure of the facilities and the immediate relocation of hundreds of residents.² During approximately the same period, MDCIS identified ten other Michigan nursing homes that, because of numerous serious deficiencies, it considered to be at risk of closure.³ These latter homes were eventually able to come back into compliance with state and federal requirements and therefore remained open. This article seeks to analyze why some of these similarly troubled facilities survived while others did not, what information would have been most useful to regulators in identifying earlier the facilities at greatest risk of closure, and what barriers existed to ensuring

2. The homes were Venoy Nursing Center in Wayne, Michigan, closed May 15, 1998; L & L Nursing Center in Detroit, Michigan, closed October 7, 1998; White Oak Manor in Mio, Michigan, closed January 12, 1999; Apple Wood Manor, Inc. in McMillan, Michigan, closed March 10, 1999; Lakeland Convalescent Center in Detroit, Michigan, closed September 7, 1999; Belle Woods Continuing Care Center in Belleville, Michigan, closed October 28, 1999; and Broadstreet Nursing Home in Detroit, Michigan, closed September 27, 2000. E-mail from Kathryn Bletz, to Carol L. Scherer et al. (Nov. 14, 2000, 02:15:00 EST) (on file with author). During the same period, a number of voluntary closures occurred, which are beyond the scope of this paper.

3. These facilities were Baywood Nursing Home in Ludington, Michigan; Bloomfield Hills Nursing Center in Bloomfield Hills, Michigan; Greenbriar Nursing Home (later known as Sterling Nursing Center) in Sterling Heights, Michigan; Heartland Health Care Center-Knollview in Muskegon, Michigan; Heartland Manor at Carriage Town in Flint, Michigan; Nightingale West Nursing Home (later known as Four Seasons Nursing Center) in Westland, Michigan; Roosevelt Park Nursing Home in Muskegon, Michigan; St. James Nursing Center in Detroit, Michigan; Tendercare-Clare in Clare, Michigan; and Woodfield Manor (later known as West Wood of Niles) in Niles, Michigan. Memorandum, Michigan Department of Consumer and Industry Services, Bureau of Health Systems (Oct. 13, 2000) (on file with author); E-mail from Michael Dankert, Director of the Division of Operations, Bureau of Health Systems (BHS), MDCIS, to Alison Hirschel (Dec. 14, 2000, 14:01:04 EST) (on file with *The Elder Law Journal*).

regulators have the best information and procedures to protect residents of seriously substandard homes and to prevent unnecessary closures.

Analysis of MDCIS records regarding the seventeen facilities during the period 1997–2000 revealed several factors that seemed especially likely to be indicators of eventual closure, and other factors that may intuitively seem likely predictors of closure, but appeared less reliable in determining facilities' fates.⁴ Not surprisingly, for far more of the homes that were forced to close than the ones that survived, there was striking evidence of severe financial distress.⁵ Moreover, a much higher percentage of homes that closed than homes that survived had long-standing and serious physical plant problems,⁶ probably due at least in part to their poor financial condition. For some of the facilities, the physical plant deficiencies were so extreme that they ultimately necessitated the immediate closure of the facility to ensure residents' safety.⁷ Yet despite the obvious potential impact on residents of facilities' financial crises and significant structural flaws, MDCIS did not have regular access to information regarding facilities' financial status or the extent of long-standing building problems.⁸

More surprisingly, some factors that seemed likely indicators of closure, such as repeated and extremely numerous citations, did not necessarily distinguish the homes that closed from the homes that managed to survive.⁹ In fact, while eight of the ten homes that survived were cited for more than twenty violations during a single survey in the period reviewed, only two of the seven homes that closed had more than twenty citations during the period under review.¹⁰

4. See discussion of factors likely to be indicators of closing *infra* Part VII.

5. See *infra* Part VII.B.

6. See *infra* Part VII.C.

7. See, e.g., HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, WHITE OAK MANOR (Jan. 5, 1999) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, WHITE OAK MANOR (Jan. 5, 1999)].

8. E-mail from Michael Dankert, Director of the Division of Operations, BHS, MDCIS, to Alison Hirschel (July 9, 2002, 14:07:35 EST) (on file with The Elder Law Journal).

9. See *infra* Part VII.F.

10. It must be noted, however, that more surveys were reviewed for facilities that remained open than for those that closed because facilities that remained open had surveys performed during the entire period of review from 1997 to 2000, while the facilities that closed obviously did not have surveys after their closure. Moreover, although extensive Freedom of Information Act requests were made of

Both state and federal regulators recognize the importance of identifying very troubled homes before a crisis develops and subjecting them to additional scrutiny.¹¹ However, neither the state, nor the federal mechanisms for determining which homes are at greatest risk consistently identified the homes in this study.¹² This failure appears to be attributable both to the regulators' lack of information about factors such as financial stability that play a key role in a facility's ultimate fate and to the resultant failure of the predictive tools to take into account a sufficiently broad range of characteristics that affect a facility's viability.

This article will explain the methodology of the study, describe characteristics of Michigan's nursing home industry, and provide an overview of state and federal survey and enforcement efforts. In addition, it will offer detailed information and analysis of the seventeen troubled facilities and set forth recommendations to ensure state and federal regulators have better tools to identify facilities at risk of closure and to intervene appropriately to provide increased and earlier protection to residents in those facilities.

The importance of enabling regulators to identify more swiftly and accurately the homes at real risk of closure cannot be overstated. As demonstrated in the discussion of the seventeen troubled facilities below, residents in facilities that close or come close to closure often live in unspeakable conditions and experience ongoing and serious abuse and neglect as their facilities deteriorate to the point that closure becomes a real possibility.¹³ Earlier intervention could spare these residents immense suffering and perhaps save dollars spent in the current system on extended surveys,¹⁴ follow-up surveys ("revisits"),¹⁵ and legal battles over proposed terminations or license revocations.¹⁶

MDCIS to obtain complete documentation of all survey results during the relevant time period, some documents were lost or unavailable at the time MDCIS provided copies of the requested information.

11. See, e.g., MICH. DEP'T OF CONSUMER & INDUS. SERVS., MICHIGAN NURSING HOME INITIATIVE, Tab 1 (Feb. 10, 1999) [hereinafter NURSING HOME INITIATIVE] (referring to *Michigan Nursing Homes At-a-Glance*); CTRS. FOR MEDICARE & MEDICAID SERVS., STATE OPERATIONS MANUAL § 7205, http://www.cms.hhs.gov/manuals/PUB_07.asp (last modified July 3, 2002) [hereinafter STATE OPERATIONS MANUAL].

12. See *infra* Part VI; E-mail from Michael Dankert, *supra* note 3 (noting that MDCIS does not have regular access to information concerning facilities' financial status).

13. See, e.g., ERICA F. WOOD, AM. ASS'N OF RETIRED PEOPLE, TERMINATION AND CLOSURE OF POOR QUALITY NURSING HOMES: WHAT ARE THE OPTIONS? (Mar. 2002), http://research.aarp.org/il/2002_05_homes.pdf.

14. STATE OPERATIONS MANUAL, *supra* note 11, app. P.

In addition, while the idea of closing substandard homes may hold some initial appeal, the resultant forced relocations of residents often cause residents and their families great distress, and some studies document increased morbidity and mortality for residents in these situations.¹⁷ This is not surprising given that frail residents are generally moved abruptly from their familiar homes, communities, and

15. *Id.*

16. *See, e.g.*, E-mail from Michael Dankert, Director of the Division of Operations, BHS, MDCIS, to Alison Hirschel (July 24, 2002, 15:30:51 EST) (regarding an example of a prolonged legal battle) (on file with author).

17. *See* Pamela S. Manion & Marilyn J. Rantz, *Relocation Stress Syndrome: A Comprehensive Plan for Long-Term Care Admissions*, GERIATRIC NURSING, May/June 1995, at 108 (describing transfer trauma as a wave of disorientation or despair resulting from the relocation of frail elderly residents from familiar surroundings and caregivers to new environments). Symptoms may include increased disorientation, depression, weight changes, anxiety, agitation, sleep disturbances, and gastrointestinal upset. *Id.*; *see also* Nancy F. Beirne et al., *Effects of a Fast-Track Closing on a Nursing Facility Population*, 20 HEALTH & SOC. WORK 116 (1995) (describing a study following sixty-nine residents who were relocated to eighteen different facilities when their original home was terminated from the Medicaid program and noting that the forty-three residents who were not returned to the facility upon recertification suffered eight times the rate of mortality and a significantly higher incidence of morbidity than the comparable group of twenty-six residents who were permitted to return to the facility); Susan M. Friedman et al., *Increased Fall Rates in Nursing Home Residents After Relocation to a New Facility*, 43 J. AM. GERIATRICS SOC. 1237 (1995) (noting that the incidence of falls doubled after the relocation of 210 residents to a new facility and stating that falls are the fifth leading cause of death in older persons and often lead to a decline in functional status and social isolation); Fredric D. Wolinsky et al., *Changes in Functional Status and the Risks of Subsequent Nursing Home Placement and Death*, 48 J. GERONTOLOGY 94 (1993). *But see* James H. Borup et al., *Relocation: Its Effect on Health, Functioning and Mortality*, 20 GERONTOLOGIST 468 (1980) (showing positive effects in stamina and functioning on 326 residents relocated from thirty homes); Peter R. Grant et al., *The Impact of an Interinstitutional Relocation on Nursing Home Residents Requiring a High Level of Care*, 32 GERONTOLOGIST 834, 836-38 (1992) (concluding that the relocation of 196 residents of two nursing homes to a new home had no negative effect on residents); James A. Thorson et al., *Relocation of the Institutionalized Aged*, 56 J. CLINICAL PSYCH. 131 (2000) (noting no increased morbidity or mortality when ninety-five residents were moved to a new facility, although residents appeared to suffer increased anxiety in the year before the long-planned move). The concept of transfer trauma has been judicially noted. *See, e.g.*, *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 802 n.10 (1980) (Blackmun, J., concurring); *Heartland Manor at Carriage Town v. Shalala*, Civ. A. No. 899-71253, at 18 (E.D. Mich. 1999) (concerning one of the homes that survived in this study); *Libbie Rehab. Ctr., Inc. v. Shalala*, 26 F. Supp. 2d 128, 132 (D.D.C. 1998); *Int'l Long Term Care, Inc. v. Shalala*, 947 F. Supp. 15, 19 (D.D.C. 1996); *Lexington Mgmt. Co. v. Mo. Dep't of Soc. Servs.*, 656 F. Supp. 36, 41 (W.D. Mo. 1986). Most recent studies start with the assumption that trauma can occur in transfers that are not carefully planned and conducted. *See, e.g.*, Thorson et al., *supra*, at 137. They therefore focus on ways to reduce the potential stress of relocation by careful and extensive preparation, measures that are rarely if ever taken in the case of emergency relocations when homes close. *See id.*

caregivers to unfamiliar facilities that may be farther away from their families and in which caregivers do not know their names, history, or needs.¹⁸ Moreover, transfers in these situations tend to be done on an emergency basis without the possibility for residents and their families to explore their options carefully and make well considered choices about alternate placements.¹⁹ Transfers often occur in an atmosphere of panic.²⁰ Numerous residents are likely to leave the facility at the same time and sometimes arrive en masse at a new facility that may be completely unprepared to absorb them. Follow-up with residents after discharge to ensure a smooth transition is usually minimal or nonexistent.²¹ As a result of these hurried mass relocations, often from a facility whose staff has already resigned, residents are frequently transferred without all of their belongings, their funds, their medications, or their records.²² In some cases, families may not be notified where the resident was transferred.²³ Finally, the closure of homes in some locations means the loss of the only nursing home in the area.²⁴ This causes great hardship for residents, their families, and consumers who need long-term care in the future.²⁵

For all of these reasons, many observers prefer, whenever possible, to replace poor managers or owners at substandard facilities rather than relocate residents and close facilities.²⁶ Currently, however, by the time facilities are identified as being in crisis, it is often impossible to find another provider willing or able to intervene and remedy the multitude of problems that have developed.²⁷ In addition to providing more prompt protection to residents, earlier identifica-

18. See Manion & Rantz, *supra* note 17, at 108–10 (explaining Relocation Stress Syndrome and examining causes and remedies to the phenomenon); see also Beirne et al., *supra* note 17, at 116–17; Wolinsky et al., *supra* note 17, at 594.

19. See generally Beirne et al., *supra* note 17 (studying the effect of sudden nursing home closings on residents and their families).

20. *Id.*

21. See Manion & Rantz, *supra* note 17, at 108 tbl. 1 (explaining factors that contribute to stress associated with the relocation of seniors, which includes lack of an adequate support system).

22. Telephone Interview with Michael Connors, Former Local Long-Term Care Ombudsman, Citizens for Better Care (July 16, 2002); Telephone Interview with Toni Wilson, Local Long-Term Care Ombudsman, Citizens for Better Care (July 16, 2002).

23. Telephone Interview with Toni Wilson, *supra* note 22.

24. *Id.*

25. *Id.*

26. Beirne et al., *supra* note 17, at 117.

27. Interview with Walt Wheeler, Director, BHS, MDCIS, in Lansing, Mich. (Oct. 23, 2000).

tion of facilities at risk and more appropriate interventions might enable facilities to recover or permit regulators to facilitate changes in ownership or management before it is too late to save the facilities.

II. Methodology

After identifying the homes that were forced to close due to license revocations between 1997 and 2000, the study sought to identify a control group of facilities that had been considered at greatest risk of closure but had managed to survive. Because many Michigan nursing homes have significant numbers of serious citations, are threatened with termination from the Medicare²⁸ or Medicaid²⁹ program, and have a long history of repeated noncompliance,³⁰ isolating an appropriate number of facilities that were actually at real risk of closure was challenging. Regulators and advocates were consulted for suggestions on how to identify facilities truly at the brink of closure. Various selection criteria were considered, including whether the facility had in fact been terminated, how many revisits by surveyors were necessary to bring homes back into compliance, and what intermediate sanctions were imposed. However, many of the proposed criteria were rejected as underinclusive, overinclusive, or unreliable.

Ultimately, homes selected for the control group were those that were required by MDCIS to hire a temporary manager to address serious deficiencies. State regulators resorted to temporary managers only when they considered a home to be in obvious jeopardy and were likely successful in persuading homes to accept the temporary manager because the regulators advised the facilities that closure was a real possibility.³¹ Admittedly, this criterion is imperfect. First, tem-

28. See 42 U.S.C. § 1395i-3 (2000).

29. See *id.* § 1396r.

30. PUB. SECTOR CONSULTANTS, INC., MICHIGAN IN BRIEF: 1998-99, <http://www.michiganinbrief.org/edition06/text/issues-44.htm> (last modified Apr. 1, 1998).

31. See, e.g., E-mail from Michael Dankert, Director of the Division of Operations, BHS, MDCIS, to Alison Hirschel (Nov. 30, 2000, 12:06:48 EST) (on file with The Elder Law Journal):

I think temporary manager is the best indicator you will find of risk of closure We view a temporary manager as a last resort. There is no current statutory, state authority to impose a temporary manager which is one reason why it is reserved for serious cases. But it is also a significant remedy. It is the closest thing to state takeover. It means we have decided a facility cannot manage itself—demonstrated by unsuccessful revisits. It could mean that things are getting worse—

porary managers were appointed in some of the homes that were forced to close as well as in all of the homes that survived.³² Moreover, the decision to impose a temporary manager is a subjective one that required regulators to assess numerous factors, perhaps including the likelihood of cooperation between the facility ownership or management and the temporary manager, the ability of the facility to pay for temporary management, the likelihood of temporary managers' willingness to work with a particular facility, the type and extent of the deficiencies, and other factors.³³ Nevertheless, the imposition of temporary managers remained the best indicator within the scope of the study to identify a facility for which there was a genuine possibility of closure.

Once the facilities were identified, the study addressed a number of key factors for each facility including:

- the size and location of the facility;
- whether the facility faced financial distress;
- whether there were serious and long-standing physical plant problems;
- whether the facility had multiple, serious citations;
- whether intermediate sanctions had been repeatedly imposed;
- whether the facility used aggressive legal strategies in response to enforcement efforts;
- the level of staffing in the facility and whether there was significant turnover of managerial staff;
- the residents' source of payment;
- whether there was a change in ownership at the facility during the period studied; and

more cites or increases in scope and severity of existing citations. It can also be things are not improving fast enough. In both cases BHS is not confident that the facility can manage its way to compliance. Since there is not statutory authority to impose a temporary manager, we generally have to get ownership to voluntarily agree to accept the manager. This we do by persuading them that closure is a real possibility.

Michigan law subsequently was amended to give MDCIS authority to appoint temporary managers. MICH. COMP. LAWS ANN. § 333.21799b (West 2001).

32. Memorandum, Michigan Department of Consumer and Industry Services, Bureau of Health Systems (Feb. 14, 2001) (on file with *The Elder Law Journal*).

33. See, e.g., WOOD, *supra* note 13, at 30-34.

- the role and duration of the temporary manager for the facilities that had them.³⁴

During the study, the author reviewed thousands of pages of documents provided by MDCIS in response to requests made pursuant to the Michigan Freedom of Information Act (FOIA).³⁵ These documents concerned the seven homes that were forced to close and the ten homes that survived after the appointment of temporary managers during the period 1997–2000, as well as MDCIS policy statements, publications, and data compilations. The documents included complaint and annual surveys for each of the facilities and correspondence between MDCIS, providers and their attorneys, individuals serving as temporary managers and consultants to facilities, and Region V staff of the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services.³⁶ In addition, the author reviewed records maintained by MDCIS concerning staffing and occupancy levels in facilities, changes in administrative staff, facility “performance scores,” used to identify homes in trouble, facilities’ administrative and legal challenges to survey and enforcement efforts, and other information related to survey and enforcement activities. Moreover, interviews were conducted with key staff at MDCIS, HCFA, and the Michigan Public Health Institute (MPHI), which created the Collaborative Remediation Project (CRP), the entity

34. However, complete information regarding all factors was not available for all facilities. For example, MDCIS records revealed that surveyors understood vendors and staff in some facilities were not being paid, or contained correspondence regarding a facility’s bankruptcy proceedings. In those cases, it was assumed that the facility was experiencing significant financial distress, but independent investigation of the facility’s financial status was beyond the scope of the study. Similarly, MDCIS materials recorded facility appeals of survey citations through the Informal Deficiency Resolution (IDR) process and contained some correspondence regarding litigation related to enforcement actions, but a complete docket of all litigation and administrative appeals related to enforcement actions was not available.

35. MICH. COMP. LAWS ANN. § 15.231 (West 2001).

36. The Health Care Financing Administration changed its name to the Centers for Medicare and Medicaid Services effective June 14, 2001. Press Release, U.S. Department of Health and Human Services, The New Centers for Medicare & Medicaid Services (CMS) (June 14, 2001), <http://www.hhs.gov/news/press/2001pres/20010614a.html>. Because the agency was known as HCFA during the period reviewed in the study, and because many of the sources cited refer to the agency in that way, it will be referred to as HCFA throughout the paper except when a more recent source is quoted in which the agency is referred to by its new appellation or when the paper discusses current procedures or recommendations for the future.

almost always selected to serve as temporary manager or to consult with and provide services to facilities with significant deficiencies.³⁷

In some cases, records were lost or unavailable and some staff at MDCIS interpreted the FOIA requests more expansively than others or included documents for slightly different time periods. Thus, documentation available for one facility may vary slightly from documentation available for other facilities. Therefore, the statistical analyses contained in this article, while informative, may not be precisely accurate and are simply intended to highlight areas for further inquiry or concern.

III. Characteristics of Michigan's Nursing Home Industry

In fiscal year 1998,³⁸ when the first of the homes were forced to close or hire temporary managers, Michigan had 458 nursing homes housing 52,271 residents.³⁹ During the period reviewed in this study, the occupancy rate hovered around 84%⁴⁰ and approximately 67% of nursing home costs were paid by the Medicaid program.⁴¹ While many facilities were owned by large chains, a number of small providers continued to operate facilities.⁴²

Until the closure of Venoy Nursing Center in May 1998, no facility had been ordered to close in Michigan in more than ten years.⁴³ However, Michigan surveyors had consistently cited facilities for numerous citations.⁴⁴ In 1999, MDCIS cited facilities for an average of 9.9 deficiencies per annual survey, compared to the national average of only 5.7 deficiencies.⁴⁵ Indeed, 97% of facilities were cited for some

37. NURSING HOME INITIATIVE, *supra* note 11, Tab 6 (referring to *Venoy Nursing Home and L & L Nursing Center Closing Reports*).

38. FY 1998 encompassed the period from October 1, 1997 to September 30, 1998. *Id.* Tab 1 (referring to *Michigan Nursing Home Surveys, FY 1997 and FY 1999*).

39. *Id.* (referring to *Michigan Nursing Homes At-a-Glance*).

40. AM. ASS'N OF RETIRED PEOPLE, *ACROSS THE STATES 2000: PROFILES OF LONG TERM CARE SYSTEMS 102* (2000) [hereinafter *ACROSS THE STATES 2000*] (citing data for 1999).

41. *Id.* at 103 (citing data for 1999).

42. Interview with Walt Wheeler, *supra* note 27.

43. NURSING HOME INITIATIVE, *supra* note 11, Tab 6 (referring to *Venoy Nursing Home Closure Report*).

44. *Id.* Tab 1 (referring to *Average Citations Per Survey for the First Three Years of OBRA Enforcement*).

45. CHARLENE HARRINGTON, THE HENRY J. KAISER FAMILY FOUND., *NURSING HOME QUALITY: STATE AGENCY SURVEY FUNDING AND PERFORMANCE 11 tbl.3* (June 2002), <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/>

level of deficiency and 47% of facilities were cited for deficiencies serious enough to be characterized as causing harm or jeopardy.⁴⁶ Between July 1998 and July 1999, Michigan ranked third in the country for the highest average number of citations per survey and second in the country for the highest percentage of surveys that cited facilities for substantial noncompliance.⁴⁷

Two active trade organizations represent Michigan nursing homes.⁴⁸ For-profit facilities are represented by the Health Care Association of Michigan (HCAM).⁴⁹ The Michigan Association of Homes and Services for the Aging advocates for the not-for-profit facilities, and county facilities have a separate organization to promote their interests.⁵⁰

IV. Characteristics of the Seventeen Troubled Facilities

All of the homes in this study were for-profit facilities.⁵¹ While none of the homes that closed belonged to large chains, some of the

getfile.cfm&PageID=14105. In the past, Michigan facilities had averaged even higher numbers of citations. For example, between July 1995 and June 1996, Michigan surveyors cited homes for an average of 11.4 citations per survey while the national average was only 5.7 citations. NURSING HOME INITIATIVE, *supra* note 11, Tab 1 (referring to *Average Citations per Survey for the First Three Years of OBRA Enforcement*). Between July 1996 and June 1997, the state averaged 9.5 citations per survey compared to the national average of only 4.9 citations. *Id.* And in the period July 1997 to June 1998, Michigan averaged 8.7 citations per annual survey while the national average dropped slightly to 4.8 citations. *Id.*

46. HARRINGTON, *supra* note 45, at 11 tbl. 3.

47. MICH. DEP'T OF CONSUMER & INDUS. SERVS., NURSING HOMES AT A GLANCE (2000).

48. Health Care Association of Michigan, at <http://www.hcam.org> (last visited Sept. 15, 2003). Michigan Association of Homes and Services for the Aging, at <http://www.mahsahome.org> (last visited Sept. 15, 2003).

49. See Health Care Association of Michigan, *supra* note 48.

50. See Michigan Association of Homes and Services for the Aging, *supra* note 48; Michigan County Medical Care Facilities Council, at <http://www.mcssa.com/mcmfc.htm> (last visited Feb. 15, 2004).

51. It is perhaps not surprising that all of the troubled homes identified were for-profit or "investor-owned" facilities. See, e.g., Charlene Harrington et al., *Does Investor Ownership of Nursing Homes Compromise the Quality of Care?*, 91 AM. J. PUB. HEALTH 1452, 1454 (2001) ("Our results suggest that investor-owned nursing homes deliver lower quality care than do non profit or public facilities. Moreover, investor-owned facilities usually are part of a chain, and chain ownership per se is associated with a further decrement in quality."). This study analyzed 1998 data from state inspections of 13,693 nursing facilities, using a multivariate model and controlling for case mix, facility characteristics, and location. *Id.* at 1452. The results demonstrated that investor-owned homes averaged 5.89 deficiencies per home, 46.5% higher than non-profit facilities and 43% higher than public facilities. *Id.*

homes that survived were part of large, multihome chains, and some were able to change owners at critical times in their licensing history.⁵² Five of the seven homes that were forced to close were located in Detroit or its nearby suburbs.⁵³ The remaining two homes that closed were owned by the same provider and located in the Upper Peninsula.⁵⁴ The homes that survived were scattered throughout the state's Lower Peninsula in urban, rural, and suburban settings.⁵⁵

The homes that closed tended to be somewhat smaller than the homes that remained open.⁵⁶ The homes that closed appeared to have a slightly higher Medicaid census than the facilities that remained open. Nevertheless, all of the homes relied heavily on Medicaid reimbursement.⁵⁷ In general, Medicaid supported over 75% of residents in

52. See generally Telephone Interview with Gwen Michel and Marilyn Samuels, Health Care Financing Administration, Region V (Mar. 2, 2001).

53. This fact may have contributed to the persistent perception that the most troubled homes in the state are located in more urban areas in Southeastern Michigan. In a recent study of public opinion about the quality of nursing homes, twice as many residents of Southeastern Michigan (where Detroit is located) rated nursing home quality as "poor" as compared to residents of other regions of the state. MAUREEN A. MICKUS & ANDREW J. HOGAN, MICH. STATE UNIV., REGIONAL VARIATIONS IN PUBLIC PERCEPTIONS OF NURSING HOME REFORM, STATE OF THE STATE SURVEY, MICHIGAN'S SORE THUMB 7 (2000).

54. See generally E-mail from Kathryn Bletz, MDCIS, to Carol Scherer, MDCIS (Nov. 14, 2000, 14:15:00 EST) (on file with author).

55. See *supra* note 3.

56. BUREAU OF HEALTH FACILITIES, MICH. DEP'T OF CONSUMER & INDUS. SERVS., COMPREHENSIVE SUMMARY OF OPEN FACILITIES FOR HLTU-ZRO, HLTU-LO, HLTU1819, HLTU19, HLTU18, HLTU1819D, HSPRES18, NH-20, NH1819, NH19, NH18, NH-ZERO, NH1819DS, CMCF-LO, CMCF1819, CMCF19, CMCF18, CMCF1819, NON-BHS (1999).

57. Each survey indicates the total number of licensed beds and the Medicaid, Medicare, and total census in the facility on the date of the survey. For example, in an October 2, 1998 survey, L & L Nursing Center had 50 beds and 40 residents, 39 of whom were Medicaid recipients. HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, L & L (Oct. 2, 1998) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, L & L NURSING CENTER (Oct. 2, 1998)]. Similarly, during a survey on June 9, 2000, Heartland Manor had 222 licensed beds, a total census of only 55, and 53 Medicaid residents. HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, HEARTLAND MANOR AT CARRIAGE TOWN (June 9, 2000) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, HEARTLAND MANOR AT CARRIAGE TOWN (June 9, 2000)]. See, for example, ADVISING THE OLDER CLIENT § 7.67 (George A. Cooney & David Shaltz, eds. 2d ed. Supp. 2003) and ERIC M. CARLSON, LONG-TERM CARE ADVOCACY § 3.04[1] (2002) for a discussion of the lower rate of payment provided by Medicaid compared to other forms of reimbursement. Beth Bacon, former Director of the Michigan Public Health Institute's Collaborative Remediation Project, who in her role at MPHI was personally familiar with most of the facilities in the study, suggested that the Medicaid census did not have a significant effect on facilities' fates. Interview with Beth Bacon (Oct. 16,

all of the homes.⁵⁸ Most of the facilities also had a small percentage of Medicare beneficiaries as well as a limited number of private pay residents.⁵⁹

All of the facilities had many serious deficiencies over a period of years and were often repeatedly cited for the same categories of deficiencies, on complaint and annual surveys.⁶⁰ Both closed facilities and temporary manager facilities were the subject of a dizzying array of intermediate sanctions imposed by the state and HCFA, including state monitoring, directed plans of correction, directed in-service trainings, civil monetary penalties, denial of payment for new admissions, bans on admission, and imposition of clinical advisors or temporary managers.⁶¹

V. Federal and State Nursing Home Survey and Enforcement Efforts

A. The Federal Survey Process

Facilities that intend to operate as nursing homes must be licensed by the state and conform to state standards.⁶² In addition, detailed federal standards for nursing homes that participate in Medicare or Medicaid are set forth in the landmark Omnibus Budget Reconciliation Act of 1987 (OBRA 87), also known as the Nursing

2000). However, since Medicaid reimbursement is lower than private pay rates or Medicare reimbursement, the higher Medicaid census may have been a factor in the financial difficulties encountered by the homes that closed.

58. Author's computation based on review of census information contained in facilities' surveys (on file with author). *See also supra* note 57.

59. Author's computation based on review of census information contained in facilities' surveys (on file with author). *See also supra* note 57.

60. *See, e.g.*, HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, FOUR SEASONS (Sept. 15, 2000) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, FOUR SEASONS (Sept. 15, 2000)]; HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, BAYWOOD NURSING HOME (Sept. 25, 1998) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, BAYWOOD NURSING HOME (Sept. 25, 1998)].

61. *See, e.g.*, MICH. DEP'T. OF CONSUMER & INDUS. SERVS., CRP REMEDIATION ACTIVITY BY FACILITY (Aug. 8, 2000) (on file with author); MICH. DEP'T. OF CONSUMER & INDUS. SERVS., FACILITY LOG, WOODFIELD MANOR (Aug. 3, 1995 to Dec. 11, 2000) (on file with author) [hereinafter FACILITY LOG, WOODFIELD MANOR]. *See also* 42 C.F.R. § 488.406 (2002).

62. MICH. COMP. LAWS ANN. § 333.20141 (West 2001).

Home Reform Act.⁶³ OBRA 87 also mandates the mechanism for surveying nursing homes and imposing sanctions for facilities that fail to meet federal requirements.⁶⁴ Under the law, the Secretary of the U.S. Department of Health and Human Services (HHS) is responsible for ensuring that facilities receiving Medicare or Medicaid funding conform to the requirements of the law.⁶⁵ HHS, through the Centers for Medicare and Medicaid Services (CMS),⁶⁶ therefore contracts with one agency in each state to conduct surveys in facilities and certify compliance with federal participation requirements.⁶⁷ In Michigan, during the period of the study, that agency was the MDCIS.⁶⁸

Pursuant to OBRA 87, nursing facilities must be inspected by the designated state agency at least once every fifteen months, and the statewide average for these “standard surveys” should not exceed twelve months.⁶⁹ These surveys must be unannounced⁷⁰ and must include a case-mix stratified sample of residents, a review of the quality of care furnished, the adequacy of written care plans and resident assessments, and compliance with residents’ rights requirements.⁷¹ Survey teams consisting of a multidisciplinary group of professionals, including a registered nurse,⁷² generally spend several days on site at the facility.

If a facility is determined to have substandard quality of care or if the Secretary determines it to be appropriate, an “extended survey”

63. Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330. The Federal Nursing Home Reform Act along with separate bills was rolled into one bill to insure final passage of all the elements.

64. 42 U.S.C. §§ 1395i-3(g)-(h), 1396r(g)-(h) (2000).

65. *Id.* §§ 1395i-3(g)(1)(A), 1396r(g)(1)(A).

66. See Press Release, *supra* note 36. The Health Care Financing Administration changed its name to the Centers for Medicare and Medicaid Services in 2001.

67. *Id.*

68. MICH. COMP. LAWS ANN. § 333.20155 (West 2001). As of December 7, 2003, the functions of the Bureau of Health Systems were transferred from MDCIS to the Michigan Department of Community Health. Mich. Dep’t of Community Health, Bureaus of Health Professions and Health Systems Join MDCH, at <http://www.michigan.gov/mdch/0,1607,7-132-27417-,00.html> (last visited Feb. 9, 2004) (summarizing the effects of Executive Order 2003-18).

69. 42 U.S.C. §§ 1395i-3(g)(2)(A)(i), (iii)(I), 1396r(g)(2)(A)(i); 42 C.F.R. §§ 488.307(a), 488.308(a), (b)(i) (2002); STATE OPERATIONS MANUAL, *supra* note 11, § 7205.

70. 42 U.S.C. §§ 1395i-3(g)(2)(A)(i), 1396r(g)(2)(A)(i); 42 C.F.R. § 488.307.

71. 42 U.S.C. §§ 1395i-3(g)(2)(A)(ii), 1396r(g)(2)(A)(ii); 42 C.F.R. § 488.305(a).

72. 42 U.S.C. §§ 1395i-3(g)(2)(E)(i), 1396r(g)(2)(E)(i); 42 C.F.R. § 488.314(a)(1); STATE OPERATIONS MANUAL, *supra* note 11, § 7201(B).

is conducted immediately.⁷³ During that survey, state surveyors are instructed to identify the policies and procedures that produced the substandard quality of care, check further for compliance with federal law, and review an increased number of resident assessments, as well as staffing, in-service training, and any contracts with consultants.⁷⁴ Federal surveyors are also required to perform “validation surveys” in at least five percent of the facilities in each state within two months of the state survey to assure state agencies are surveying facilities consistent with federal requirements and procedures.⁷⁵

In addition to these surveys, annual Life Safety Code evaluations are performed for every facility.⁷⁶ The state survey agency must also conduct surveys in response to complaints.⁷⁷ These surveys generally involve a single surveyor, must be unannounced, and focus on the specific allegations of the complaint.⁷⁸ After investigation, surveyors determine whether or not to substantiate the complaint and cite the facility.⁷⁹

The survey results are set forth on HCFA Form 2567, entitled “Statement of Deficiencies and Plan of Correction.” This document includes information about the facility, the names of the surveyors, the federal requirement that has been violated, and specific details of

73. 42 U.S.C. §§ 1395i-3(g)(2)(B)(i)–(ii), 1396r(g)(2)(B)(i)–(ii). “Substandard Quality of Care” is defined as

one or more deficiencies related to participation requirements under § 483.13, Resident behavior and facility practices, § 483.15, Quality of life, or § 483.25, Quality of care of this chapter, which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

42 C.F.R. § 488.301.

74. 42 U.S.C. §§ 1395i-3(g)(2)(B)(iii), 1396r(g)(2)(B)(iii).

75. *Id.* §§ 1395i-3(g)(3)(B), 1396r(g)(3)(B).

76. MICH. COMP. LAWS ANN. § 333.20156 (West 2001).

77. 42 U.S.C. §§ 1395i-3(g)(4)(A), 1396r(g)(4)(A).

78. MICH. COMP. LAWS ANN. § 333.20155(1); MICH. DEP’T OF CONSUMER & INDUS. SERVS., A CITIZEN’S GUIDE TO FILING A COMPLAINT AGAINST A LICENSED HEALTH CARE FACILITY 2 (2003), http://www.michigan.gov/documents/cis_bhs_fhs_bhs_ops_700_35709_7.pdf.

79. *See, e.g.*, DIV. OF HEALTH FACILITY LICENSING & CERTIFICATION, MICH. DEP’T OF CONSUMER & INDUS. SERVS., COMPLAINT INVESTIGATION MANUAL pt. 3, at 8 (1999) [hereinafter COMPLAINT INVESTIGATION MANUAL].

the alleged violation.⁸⁰ The form also includes space for the facility to set forth its plan of correction for each violation.⁸¹

Citations are based on seventeen major categories of requirements, such as Quality of Care or Physical Environment,⁸² and are categorized in terms of their “scope” and “severity.”⁸³ HCFA has created a twelve box grid in which the citations can be plotted according to their scope and severity.⁸⁴ Each box is assigned a letter from A to L.⁸⁵ A level citations have the most modest scope and severity while L level citations constitute widespread immediate jeopardy, the most serious level of violation.⁸⁶ The letter assigned to each deficiency is noted on the HCFA Form 2567.⁸⁷

Facilities that wish to challenge particular citations can utilize the Informal Deficiency Resolution (IDR) process conducted by the Michigan Peer Review Organization (MPRO).⁸⁸ MPRO conducts a paper review of the citation and both the facility and MDCIS can submit documentation in support of their position.⁸⁹ After reviewing each claim, MPRO will support the citation in full, amend the citation by deleting examples or changing the scope and severity, or delete the citation.⁹⁰ The vast majority of citations are supported in full.⁹¹

80. See, e.g., STATEMENT OF DEFICIENCIES, WHITE OAK MANOR (Jan. 5, 1999), *supra* note 7.

81. *Id.*

82. See 42 C.F.R. § 483 (2002).

83. “Scope” refers to whether the violation is isolated, a pattern in the facility, or widespread. “Severity” refers to whether the violation causes no actual harm and has the potential only for minimal harm, causes no actual harm but has the potential for more than minimal harm that is not immediate jeopardy, causes actual harm that is not immediate jeopardy, or causes immediate jeopardy. See 42 C.F.R. § 488.404(b); see also STATE OPERATIONS MANUAL *supra* note 11, § 7400, at 7-50.

84. STATE OPERATIONS MANUAL, *supra* note 11, § 7400, at 7-50.

85. *Id.*

86. *Id.*

87. See *id.* at 2-137; see also, e.g., STATEMENT OF DEFICIENCIES, WHITE OAK MANOR (Jan. 5, 1999), *supra* note 7.

88. MICH. DEP’T OF CONSUMER & INDUS. SERVS., BUREAU OF HEALTH SYS., INFORMAL DEFICIENCY RESOLUTION FOR LONG-TERM CARE FACILITIES (2003), http://www.michigan.gov/documents/cis_bhs_fhs_informal_deficiency_resolution_37433_7.pdf [hereinafter INFORMAL DEFICIENCY RESOLUTION].

89. *Id.*

90. *Id.*

91. See MICH. DEP’T OF CONSUMER & INDUS. SERVS., NURSING HOME SURVEY REPORT (Sept. 2001), http://www.michigan.gov/documents/cis_FAST_scc321_2_35155_7.pdf, at 2 [hereinafter NURSING HOME SURVEY REPORT]. In the period from September 1, 2000, to August 31, 2001, providers appealed 8.2% of all citations issued to the Informal Deficiency Resolution (IDR) Process. *Id.* Of all citations issued by the state during this period, 98% were either not appealed or supported in

B. The Federal Enforcement System

Enforcing federal requirements in nursing homes, like surveying the facilities, involves both state and federal agencies.⁹² If a Medicare certified home is found to have deficiencies, MDCIS makes recommendations to CMS about appropriate sanctions, and CMS makes the final decision about which sanctions to impose.⁹³ CMS generally accepts the state's recommendations.⁹⁴ In homes that are certified to provide Medicaid only, the state has final authority to impose sanctions.⁹⁵

Both federal and state law provide a framework for choosing appropriate sanctions based on the severity of the deficiencies.⁹⁶ However, regulators have significant latitude in selecting from a range of sanctions.⁹⁷ As noted above, these sanctions include "intermediate sanctions," such as civil monetary penalties, denials of payment by Medicare or Medicaid, state monitoring, temporary management,⁹⁸ and directed plans of correction or directed in-service training, as well as alternative or additional state remedies approved by CMS.⁹⁹ Facilities are also required to be barred for two years from conducting nurse aide training and competency evaluation programs in certain circumstances.¹⁰⁰ Regulators may terminate facilities from

full by the Michigan Peer Review Organization. *Id.* It is important to note that "the number of citations supported, amended, and deleted does not equal the number of citations appealed because some are still pending at the end of this reporting period." *Id.*

92. See U.S. GEN. ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL REQUESTERS, NURSING HOMES: ADDITIONAL STEPS NEEDED TO STRENGTHEN ENFORCEMENT OF FEDERAL QUALITY STANDARDS (Mar. 1999), http://www.ascp.com/public/ga/gao_report.pdf [hereinafter GAO, ADDITIONAL STEPS NEEDED].

93. 42 C.F.R. § 488.330(a)(1)(A)(c) (2002); STATE OPERATIONS MANUAL, *supra* note 11, § 7300(B).

94. GAO, ADDITIONAL STEPS NEEDED, *supra* note 92, at 5.

95. STATE OPERATIONS MANUAL, *supra* note 11, § 7303.

96. 42 U.S.C. §§ 1395i-3(h), 1396r(h) (2000); 42 C.F.R. § 488.404; MICH. COMP. LAWS ANN. §§ 333.21799b, 21799c, 21799d, 21799e (West 2001).

97. See 42 C.F.R. §§ 488.404–.430.

98. *Id.* § 488.406(b); STATE OPERATIONS MANUAL, *supra* note 11, § 7400(C); see also 42 U.S.C. §§ 1395i-3(h)(2)(B), 1396r(h)(2)(A).

99. 42 C.F.R. § 488.406; see also 42 U.S.C. §§ 1395i-3(h)(2)(B), 1396r(h)(2)(A).

100. 42 U.S.C. §§ 1396r(f)(2)(B), 1395i-3(f)(2)(B); 42 C.F.R. § 483.151(b)(2). This provision, known as the "nurse aide lock-out," can be costly for facilities that are forced during the lock-out period to pay others to provide federally mandated training to new nursing assistants. 42 C.F.R. § 483.151(b)(3).

Medicare or Medicaid when they deem it appropriate,¹⁰¹ but are likely to choose this most severe sanction only in egregious situations in which a facility demonstrates immediate jeopardy.¹⁰² Regulators are required to terminate if a facility has been out of substantial compliance for six months.¹⁰³

A recent study conducted by the AARP Public Policy Institute concluded that intermediate sanctions are used irregularly and that the sanctions do not always result in a correction of the violation.¹⁰⁴ Similarly, the General Accounting Office reported in 1999 that “[s]anctions initiated by HCFA against noncompliant nursing homes were never implemented in a majority of cases and generally did not ensure that the homes maintained compliance with standards.”¹⁰⁵ In most cases, facilities are given an opportunity to correct deficiencies before a sanction is actually imposed.¹⁰⁶ In a 1999 report, the General Accounting Office noted that, nationally, 99% of facilities with deficiencies were granted a grace period to correct deficiencies.¹⁰⁷ Many facilities have histories of “yo-yo” compliance in which

HCFA would give notice to impose a sanction, the home would correct its deficiencies, HCFA would rescind the sanction, and a subsequent survey would find that problems had returned. The

101. 42 U.S.C. §§ 1395i-3(h)(4), 1396r(h)(5), (7); *see also* STATE OPERATIONS MANUAL, *supra* note 11, § 7400(E)(1) (discussing factors to be considered when selecting remedies for a facility’s noncompliance).

102. *See* 42 U.S.C. § 1396r(h)(5).

103. *See id.* §§ 1395i-3(h)(2)(C), 1396r(h)(3)(D); 42 C.F.R. § 488.412(d); STATE OPERATIONS MANUAL, *supra* note 11, § 7301(B)(3).

104. *See* WOOD, *supra* note 13, at 20–25.

105. GAO, ADDITIONAL STEPS NEEDED, *supra* note 92, at 3.

106. *See* U.S. GEN. ACCOUNTING OFFICE, REPORT TO THE SPECIAL COMMITTEE ON AGING, U.S. SENATE, CALIFORNIA NURSING HOMES: CARE PROBLEMS PERSIST DESPITE STATE AND FEDERAL OVERSIGHT 26 (July 1998) [hereinafter GAO, CALIFORNIA NURSING HOMES] (asserting that 99% of facilities across the country were granted grace periods before sanctions were imposed). However, pursuant to a Clinton administration initiative, state survey agencies are now being directed to impose sanctions immediately without an opportunity to correct when:

- (a.) The facility has deficiencies indicating actual harm (Level G) or above on the current survey, and on the previous standard survey or any intervening survey;
- (b.) The facility was previously terminated from the Medicare and/or Medicaid programs and has deficiencies causing actual harm on the first survey after re-entry into the Medicare/Medicaid program;
- (c.) The facility is cited for immediate jeopardy; or
- (d.) The facility has noncompliance for which a per instance civil monetary penalty was imposed.

STATE OPERATIONS MANUAL, *supra* note 11, § 7304(B); *see also* NURSING HOME SURVEY REPORT, *supra* note 91, at 7 (discussing “Level 6” deficiencies).

107. GAO, CALIFORNIA NURSING HOMES, *supra* note 106.

threat of sanctions appeared to have little effect on deterring homes from falling out of compliance again because homes could continue to avoid the sanctions' effect as long as they kept correcting their deficiencies.¹⁰⁸

C. State Survey and Enforcement Efforts

During the period of this study, MDCIS employed approximately 100 surveyors divided into six regional teams consisting of nurses, pharmacists, sanitarians, social workers and dietitians.¹⁰⁹ During fiscal year 1998, it conducted 403 standard surveys during which it cited 3583 violations and identified only 15 facilities without any violations.¹¹⁰ It received approximately 2500 complaints,¹¹¹ conducted 1075 complaint visits,¹¹² and substantiated approximately 25% of the complaints.¹¹³ In addition, it conducted 473 revisits to check compli-

108. GAO, ADDITIONAL STEPS NEEDED, *supra* note 92, at 3. MDCIS responded to this comment:

It is our view that it is not just the **threat** of sanctions that is important to achieving sustained compliance, but the **type** of sanction that is used. The favored enforcement options should be those which (1) promote deterrance [sic] (prevention) by having a financial impact on the home quickly after a deficiency is found; (2) compel a home to address and correct the reasons for noncompliance in a professionally sound manner; and (3) assure that the corrective steps are maintained even after the date that "substantial compliance" is declared.

Michigan has employed denial of payment for new admissions and bans on admission as a favored sanction for homes needing early intervention, as well as directed plans of correction, directed in-service training, and placement of approved clinical advisors and temporary managers at facility expense. Oversight continues for periods up to six months **after** substantial compliance is achieved to assure that systemic changes have been made.

Id. app. at 48 (quoting Michigan's Comments on Enforcement of Federal Quality Standards from March 9, 1999).

109. NURSING HOME INITIATIVE, *supra* note 11, Tab 1 (referring to *Michigan Nursing Homes At-A-Glance*).

110. *Id.* (referring to *Michigan Nursing Home Surveys*).

111. *Id.* (referring to *Michigan Nursing Homes At-A-Glance*).

112. *Id.* (referring to *Michigan Nursing Home Surveys*).

113. *Id.* (referring to *Michigan Nursing Homes At-A-Glance*). Michigan's complaint-handling system was severely criticized by the U.S. General Accounting Office, which revealed that even very serious complaints were often not investigated for weeks or months. U.S. GEN. ACCOUNTING OFFICE, REPORT TO CONGRESSIONAL REGISTERS, NURSING HOMES: COMPLAINT INVESTIGATION PROCESSES OFTEN INADEQUATE TO PROTECT RESIDENTS 9 (Mar. 1998) [hereinafter GAO, COMPLAINT INVESTIGATION]. MDCIS has since taken steps to improve the speed with which it handles complaint investigations. GAO ADDITIONAL STEPS NEEDED, *supra* note 92, at 47-52.

ance with requirements at facilities with significant citations.¹¹⁴ When revisits were not conducted, MDCIS simply accepted the facility's "attestation" that the violations had been corrected.¹¹⁵

MDCIS reviewed facilities' survey findings and licensing histories when determining which enforcement remedies to recommend imposing.¹¹⁶ In 1998, MDCIS imposed sixty-five directed plans of correction, forty-seven denials of payment for new admissions, twenty-eight directed in-service trainings, twenty-three civil monetary penalties, and fifteen bans on admissions, as well as eight temporary managers and a handful of other remedies.¹¹⁷ In 1997 and 1998, MDCIS created the "Resident Protection Initiative," a program designed to increase the effectiveness and efficiency of its survey and enforcement functions.¹¹⁸ Perhaps MDCIS's most significant initiative was its col-

114. NURSING HOME INITIATIVE, *supra* note 11, Tab 1 (referring to *Michigan Nursing Home Surveys*).

115. See, e.g., FACILITY LOG, WOODFIELD MANOR, *supra* note 61, at 1; MICH. DEP'T. OF CONSUMER & INDUS. SERVS., FACILITY LOG, BELLE WOODS CONTINUING CARE CENTER 3 (Sept. 26, 1996 to Oct. 29, 1999) (on file with author) [hereinafter FACILITY LOG, BELLE WOODS]; MICH. DEP'T. OF CONSUMER & INDUS. SERVS., FACILITY LOG, HEARTLAND MANOR AT CARRIAGE TOWN 5, (July 31, 1995 to Jan. 25, 2001) (on file with author) [hereinafter FACILITY LOG, HEARTLAND MANOR]. See also, e.g., MICH. DEP'T OF CONSUMER & INDUS. SERVS., BHS, FACILITY ATTESTATION TO THE CORRECTION OF DEFICIENCIES, VENOY NURSING CENTER (Oct. 27, 1997) (on file with author).

116. NURSING HOME INITIATIVE, *supra* note 11, Tab 5 (referring to *Selection Criteria for Enforcement Action*). According to MDCIS, the following criteria were considered:

- Staff instability (Facility Management)
- Repeat Quality Indicator Citations from previous standard survey cycle
- Poor Performance in previous standard survey cycle
- Ineffectiveness of enforcement actions in previous standard survey cycle
- Inability to sustain compliance since last standard survey cycle
- If the scope/severity of citations at revisit increased from the previous visit
- If minimal progress has been made in correcting citations
- Non-implementation or ineffective implementation of Plans of Correction
- Repeat Quality Indicator Citations (within current survey cycle)
- New citations
- History of facility's inability to achieve compliance
- History of facility's inability to sustain compliance
- If previous enforcement actions were ineffective
- Results of reports from the Collaborative Remediation Project, if available
- Refusal to accept remediation approach
- Resistance to remediation
- Other factors

Id.

117. *Id.* Tab 1 (referring to *Michigan Enforcement Actions 1997 and 1998*).

118. According to MDCIS, the initiative included:

laboration with MPHI, a non-profit corporation created to assist the Michigan Department of Community Health (MDCH), other state agencies, and several Michigan universities in promoting public health.¹¹⁹ Pursuant to a contract with MDCIS, MPHI developed a “Collaborative Remediation Project” to “assist long-term care providers in the achievement and maintenance of compliance with licensure and certification requirements [and to] provide education to residents and their families.”¹²⁰ Funding for the project came from fines already collected at the state and federal levels as well as from fees MPHI was authorized to charge facilities for services it provided to them.¹²¹

For the Collaborative Remediation Project (the Project), MPHI developed a list of dozens of trained “consultant-remediators,” many of whom were former surveyors and licensed nurses and nursing home administrators.¹²² When MDCIS identified a facility with significant violations, it could choose to refer the facility to the Project as an alternative to other enforcement remedies.¹²³ Remediators identified by MPHI would then enter into contracts with the facilities to coordinate directed plans of correction and directed in-service trainings or to serve as clinical advisors or temporary managers.¹²⁴ Facilities were responsible for paying the remediators for their services and

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- A distinct enforcement unit, later upgraded to a Division, to oversee and coordinate federal and state nursing home enforcement actions;
 - A new enforcement data system to track facility performance and streamline enforcement activities;
 - A computer-based formula to identify facilities for early enforcement;
 - A new Medicaid Bulletin which officially coordinated state and federal enforcement and federal mandates for early intervention for facilities characterized as “poor performers;”
 - Expanded monitoring and rehabilitation of problem nursing homes by working with the private sector;
 - A timely and objective Informal Deficiency Dispute Resolution . . . process with the assistance of the Michigan Peer Review Organization.

Id. Tab 2 (referring to *Resident Protection Initiative*).

119. *Id.*

120. *Id.* Tab 6 (referring to *A Sample of 1997 Projects*).

121. *Id.* Tab 6 (referring to *Collaborative Remediation Agency Project*).

122. *Id.* Tab 2 (referring to *Resident Protection Initiative*).

123. See generally *id.* Tab 6 (referring to *Collaborative Remediation Agency Project*).

124. Although MPHI was generally appointed to serve as temporary manager, a Wisconsin agency was appointed to serve as the temporary manager for one facility. E-mail from Michael Dankert, Director of the Division of Operations, BHS, MDCIS, to Alison Hirschel (Dec. 14, 2000, 12:02:18 EST) (on file with author).

remediators were obligated to provide frequent and timely reports to MDCIS about progress in the facility.¹²⁵

Some facilities received services from MPHI on more than one occasion.¹²⁶ Some refused to pay or ceased paying for services resulting in the cessation of remediation.¹²⁷ The degree of cooperation exhibited by facilities, the extent of MPHI's authority, the duration of the remediation effort, the number of remediators assigned to each site, and the ability of the remediators to initiate long-standing improvements all varied greatly.¹²⁸ Nevertheless, in 1998, MPHI remediators were involved in all of the state's directed plans of correction and directed in-service trainings and served as clinical advisors in fifteen facilities and temporary managers in eight facilities, including the homes profiled in this study.¹²⁹

Because of its involvement in some of the state's most troubled homes and its frequent communication and often long standing relationships with MDCIS staff, MPHI played an extremely important role in the state's enforcement efforts and the troubled homes' ultimate fates.¹³⁰ Indeed, its role was often a difficult one. At the same time the remediators were trying to build trust and relationships with the facility staff, they were required to submit frequent reports to MDCIS.¹³¹ The focus of the reports was intended to be the progress made on the citations in the survey that led to the appointment of MPHI as temporary manager.¹³² However, remediators in the course

125. NURSING HOME INITIATIVE, *supra* note 11, Tab 6 (referring to *Collaborative Remediation Agency Project*). See also, e.g., MICH. DEP'T OF CONSUMER & INDUS. SERVS. CORRECTION NOTICE ORDER (Sept. 29, 2000), Attachment A (regarding "Duties of the [Temporary] Manager" which states, "Beginning 7 days after the execution of this Agreement, the Manager shall provide the Department and facility with weekly written reports.") (on file with author).

126. NURSING HOME INITIATIVE, *supra* note 11, Tab 7 (referring to *HCFA Required Increased*). See, e.g., MICH. DEP'T. OF CONSUMER & INDUS. SERVS. FACILITY LOG, NIGHTINGALE WEST NURSING HOME (Aug. 8, 1995 to Dec. 20, 2000), at 3, 5, 7 (on file with author) [hereinafter FACILITY LOG, NIGHTINGALE WEST]; see also MICH. DEP'T. OF CONSUMER & INDUS. SERVS., CRP REMEDIATION ACTIVITY BY FACILITY, *supra* note 61.

127. Interview with Beth Bacon, *supra* note 57.

128. See generally NURSING HOME INITIATIVE, *supra* note 11, Tabs 1-2.

129. *Id.* Tab 2 (referring to *Overview of Residence Protection Initiative Early & Effective Enforcement*).

130. *Id.* (referring to *State Sets to Improve Care Homes*).

131. See generally *id.* Tab 6 (referring to *Collaborative Remediation Agency Project*).

132. See, e.g., REHABILITATION CARE CONSULTANTS FACILITY/REMEDIATOR PROGRESS REPORT (June 26, 1998) (regarding progress made on each citation for which Nightingale West was cited prior to the appointment of Rehabilitation Care Consultant as temporary manager for the facility) (on file with author).

of their efforts also often uncovered other serious issues that had not been previously cited and their response to these issues and their communication with MDCIS about them was often a delicate matter.¹³³ It may have been unclear to some of the parties whether MPHI was serving in the role as consultant to the facility that paid them or as an arm of the enforcement agency that required the facility to enter into a contract with them.

MDCIS became thoroughly invested in the collaborative remediation concept and substantially shifted its enforcement actions to those in which MPHI could participate.¹³⁴ MDCIS created the Collaborative Remediation Project in 1997. MDCIS imposed forty-two civil monetary penalties and required only six directed plans of correction.¹³⁵ In 1998, MDCIS imposed only twenty-three civil monetary penalties¹³⁶ and increased the number of directed plans of correction more than tenfold to sixty-five.¹³⁷

Because MPHI was involved both in facilities profiled in this study that failed and in facilities that survived, it did not, despite the apparent skill, energy, and dedication of some of the remediators, serve as a panacea for troubled facilities. However, while regulators and advocates across the country complain that temporary managers are rarely imposed in their states because there is a dearth of qualified candidates available to take over very challenging facilities at extremely short notice,¹³⁸ an advantage of the Collaborative Remediation Project was that it could provide qualified individuals and teams who were able to move swiftly to assist facilities in crisis across the state.

When serving as remediators, MPHI certainly had an incentive to provide MDCIS with the results it sought and to maintain excellent relationships with MDCIS staff so that MDCIS would continue to rely on it. At the same time, MDCIS, having made a substantial commitment to the concept of collaborative remediation in general and to MPHI in particular, had an incentive to view and present MPHI's ef-

133. See, e.g., REHABILITATION CARE CONSULTANTS FACILITY/REMIATOR PROGRESS REPORT (Aug. 7, 1998) ("Facility staff have not yet internalized standards of acceptable care. Facility staff with responsibility for monitoring and supervision do not readily identify poor performance.") (on file with author).

134. See generally NURSING HOME INITIATIVE, *supra* note 11, Tab 5 (referring to Collaborative Remediation Project).

135. *Id.* Tab 1 (referring to Enforcement Actions 1997 and 1998).

136. *Id.* Tab 2 (referring to Michigan Enforcement Actions 1997 and 1998).

137. *Id.*

138. WOOD, *supra* note 13, at 33.

forts as highly successful. To date, however, no formal studies have been conducted on MPHI's success in creating lasting improvements in facilities or addressing specific issues.

Some commentators remain skeptical about collaborative remediation as an effective enforcement tool. When the Institute of Medicine completed its landmark study on nursing home regulation which led to the passage of the Nursing Home Reform Law, it noted that state enforcement suffered when state survey agencies tried to act as consultants as well as enforcers.¹³⁹ Similarly, Senator Charles Grassley, former Chairman of the U.S. Senate Special Committee on Aging, noted, "[a]lthough there may be a place for consultation in the ongoing relationship between the federal health programs and those who participated in these programs, it cannot be to the detriment of strong enforcement of the federal quality of care standards," and he alleges that collaboration weakened the initial implementation of the Nursing Home Reform Law.¹⁴⁰ Although in the MPHI model, MDCIS itself is not serving as the remediator, the close relationship between MDCIS and MPHI and MDCIS's strong and public commitment to the collaborative remediation model raises questions about whether MDCIS's enforcement efforts have been positively or adversely affected.

VI. Federal and State Efforts to Identify the Most Troubled Facilities—Regulators' Unreliable Predictive Tools

A. Introduction

Both Michigan and the HCFA acknowledged the importance of providing the greatest degree of oversight to homes in which residents were at the greatest risk, and both developed procedures to try to identify those facilities. However, these tools only haphazardly identified facilities in the study that were at greatest risk of closure.

139. INST. OF MED., *IMPROVING THE QUALITY OF CARE IN NURSING HOMES* 149 (1986).

140. Charles Grassley, *The Resurrection of Nursing Home Reform: A Historical Account of the Recent Revival of the Quality Care Standards for Long-Term Care Facilities Established in the Omnibus Reconciliation Act of 1987*, 7 *ELDER L.J.* 267, 282 (1999).

B. HCFA “Poor Performing Facilities”

HCFA established criteria for identifying some nursing homes as “poor performing” facilities and later changed its terminology to “no opportunity to correct” facilities.¹⁴¹ During 1998, HCFA revised that criteria to strengthen enforcement.¹⁴² Facilities designated as “poor performers” were given no opportunity to correct deficiencies before the imposition of remedies.¹⁴³ None of the homes that were required to close in the study were identified as poor performers at the time of closure, however.¹⁴⁴

C. HCFA Special Focus Facilities

HCFA also attempted to increase scrutiny of particularly troubled homes by requiring state survey agencies to conduct standard surveys on “special focus facilities” every six months instead of once every nine to fifteen months.¹⁴⁵ HCFA created a numerical score for every facility based on the number and type of serious deficiencies and the number and type of substantiated complaints.¹⁴⁶ Scores were then ranked by state and the four highest scoring facilities for each state were selected for the list.¹⁴⁷ States then were required to choose at least two facilities from the list on which to impose the additional scrutiny.¹⁴⁸ Facilities were to remain on the list until they achieved two annual surveys with no deficiencies at or above the *F* level and

141. E-mail from Michael Dankert, Director of the Division of Operations, BHS, MDCIS, to Alison Hirschel (Feb. 27, 2003, 15:10:30 EST) (on file with *The Elder Law Journal*).

142. STATE OPERATIONS MANUAL, *supra* note 11, § 7304.B; Memorandum from Acting Director, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, to Associate Regional Administrators and State Agency Directors, Change in Mandatory Criteria Used to Make “Poor Performing Facility” Determination (Sept. 22, 1998) (on file with author).

143. Memorandum from Acting Director, *supra* note 142.

144. E-mail from Michael E. Dankert, Director of the Division of Operations, BHS, MDCIS, to Alison Hirschel (July 12, 2002, 14:35:41 EST) (on file with author).

145. See U.S. GEN. ACCOUNTING OFFICE, NURSING HOMES, HCFA INITIATIVES TO IMPROVE CARE ARE UNDERWAY BUT WILL REQUIRE CONTINUED COMMITMENT 10 (June 30, 1999), <http://www.gao.gov/archive/1999/he99155t.pdf>.

146. HEALTH CARE FIN. ADMIN., CHICAGO REGIONAL OFFICE, DIVISION OF MEDICAID AND STATE OPERATIONS, ELECTRONIC REGIONAL PROGRAM LETTER TO STATE SURVEY AGENCY DIRECTORS, REGARDING “SPECIAL FOCUS FACILITIES—IMMEDIATE ACTION” (Jan. 18, 1998) [hereinafter IMMEDIATE ACTION]. See also HEALTH CARE FIN. ADMIN., <http://www.hcfa.gov/medicaid/reports/rpfall00.pdf>, at 10 (last visited June 20, 2002) (on file with author).

147. See IMMEDIATE ACTION, *supra* note 146.

148. *Id.*

had no substantiated complaints for one year or were terminated.¹⁴⁹ The designations of special focus facilities was implemented in January 1999.¹⁵⁰

State regulators complained that HCFA's "special focus facilities" designation was problematic because once the two homes were selected as special focus facilities, they had enormous difficulty meeting the federal criteria to be removed from the list.¹⁵¹ However, the original list of four facilities HCFA proposed as potential special focus facilities included Applewood Manor, a home that closed, and Tendercare Clare, a facility that survived, as well as two homes not included in the study.¹⁵² MDCIS selected Applewood and Tendercare Clare from the list of four choices.¹⁵³ Applewood remained on the list until closure when it was replaced by a home not included in this study, and Tendercare Clare remained on the list almost three years, until October 2001.

Thus, 50% of HCFA's list of four potential special focus facilities were homes in this study and both of MDCIS's original choices for its two special focus facilities were facilities included in this study. This tool did therefore flag extremely troubled homes. However, because only two special focus facilities are designated in the state and because facilities tend to remain on the list for a long time, this tool was too narrow to identify all of the homes at great risk of closure and too inflexible to be adjusted if other facilities eventually appeared to be at greater risk than the facilities identified as long-standing special focus facilities.

D. MDCIS Performance Scores

MDCIS created a similar formula for assessing facility performance. These "performance scores" take into account standard survey results, complaint histories, and the number of revisits required in the

149. *Id.*

150. Memorandum from David A. Rector, Chief, Field Services Lansing/Graylord Section, MDCIS, to Carol L. Scherer, MDCIS (Jan. 16, 2001, 09:59:00 EST) (on file with *The Elder Law Journal*).

151. Interview with David A. Rector, Chief, Field Services, Lansing/Graylord Section, Division of Nursing Homes Monitoring, BHS, MDCIS, in Lansing, Mich. (Dec. 5, 2000).

152. Memorandum from David A. Rector, *supra* note 150. This designation was introduced after the closure of both Venoy Nursing Center and L & L Nursing Center. *Id.*

153. *Id.*

previous survey cycle to achieve substantial compliance.¹⁵⁴ Under the MDCIS model, a numeric score is given to every citation in a complaint or standard survey, depending on its scope and severity.¹⁵⁵ For example, an *F* level violation, indicating a widespread violation that has not caused actual harm but had the potential for more than minimal harm, is scored as six points, while an *L* level violation for a widespread violation causing immediate jeopardy counts for 150 points.¹⁵⁶ Substandard quality of care (SQoC) citations add additional points, with less serious SQoC violations adding fewer points than higher level citations.¹⁵⁷ In addition, facilities are assigned 50, 75, or 100 additional points if second, third, or fourth revisits are required before the facility achieved substantial compliance, and 250 points are added if the facility is terminated from the Medicare and Medicaid program.¹⁵⁸ The survey score, complaint score, and extended noncompliance scores are then added together to determine the total performance score.¹⁵⁹

Four times each year, MDCIS calculates the total performance score for every facility surveyed in the previous quarter.¹⁶⁰ It determines the average score for facilities and identifies facilities whose scores are one or more standard deviations from the average score.¹⁶¹ Facilities at or above that trigger score for that quarter receive early review or intervention.¹⁶² “Early intervention” is defined as applying one or more enforcement remedies without waiting for the first revisit and was designed to flag facilities with “significantly poor standard surveys . . . significant substantiated complaints . . . or significant difficulty coming into compliance with standards in the past.”¹⁶³ Performance score reports are issued quarterly and cover the period of time two quarters before the date of the report.¹⁶⁴ During the period

154. NURSING HOME INITIATIVE, *supra* note 11, Tab 4 (referring to *Michigan's Facility Performance Audit System*).

155. *Id.*

156. *Id.*; see also MICH. DEP'T OF CONSUMER & INDUS. SERVS., EARLY INTERVENTION PROGRAM—OVERVIEW (Sept. 10, 1997) [hereinafter EARLY INTERVENTION PROGRAM] (on file with The Elder Law Journal).

157. NURSING HOME INITIATIVE, *supra* note 11, Tab 4 (referring to *Michigan's Facility Performance Audit System*).

158. *Id.*

159. *Id.*

160. *Id.*

161. *Id.*

162. *Id.*

163. *Id.*

164. *Id.*

reviewed in this study, homes that closed appeared ten times on the performance score reports and, half the time, their scores were below the trigger score indicating the need for early intervention.¹⁶⁵ For example, in a report dated five months before Broadstreet closed, the facility did not meet the trigger score for early intervention.¹⁶⁶ Similarly, nine months before it closed, a performance score report gave L & L an extremely low score, suggesting no need for early intervention.¹⁶⁷ And, a report that was dated the month after Lakeland closed listed the facility's performance score as far below the trigger point and with a better score than more than half the facilities surveyed during that period.¹⁶⁸

Not surprisingly, the facilities that survived generally had scores above the trigger point on performance score reports dated around the time the temporary managers were appointed and occasionally during other periods as well.¹⁶⁹ During periods more distant from the time in which a temporary manager was required, the facilities that survived often did not have particularly high scores and some showed significant improvement.¹⁷⁰ Just over a year after it required a temporary manager, West Wood of Niles had one of the best scores in the quarter.¹⁷¹

Although the performance score report does identify homes as needing early intervention when their crises are most apparent, it does not give regulators sufficient indication of homes that are likely to deteriorate in time to take effective preventive measures. Like the other tools, it does not take into account evidence of financial instability or physical plant problems, except to the extent that those issues are identified as deficiencies. And since deficiencies in those areas often tend to be cited not at all or at a low level until a real crisis develops, the performance score gives regulators information too late to

165. Information pertaining to facilities' performance scores was derived from Michigan Department of Consumer and Industry Services' quarterly reports entitled, *Care*Net: Nursing Home Full Performance History Report* dated Jan. 6, 1998, Apr. 1, 1998, July 1, 1998, Aug. 5, 1998, Jan. 6, 1999, Apr. 2, 1999, July 1, 1999, Oct. 7, 1999, Jan. 11, 2000, Apr. 3, 2000, July 11, 2000, and Oct. 2, 2000 (on file with The Elder Law Journal).

166. *Id.* Apr. 1, 1998.

167. *Id.* Jan. 6, 1998.

168. *Id.*

169. *See generally id.* (reporting Michigan nursing home scores).

170. *Id.*

171. *See id.* July 11, 2000 (reporting West Wood's score).

adequately protect residents who will be at risk and to intervene appropriately in homes that may face closure.

VII. Analysis and Discussion of Key Facility Characteristics

A. Facility Size and Ownership

The homes that closed tended to be somewhat smaller than the homes that remained open. For example, three of the closed homes had 50 or fewer beds, while two had between 50 and 100 beds and two had more than 150 beds.¹⁷² Of the homes that survived, none had fewer than fifty beds, two had between fifty and 100, five had between 101 and 150 beds, and three were larger than 150 beds.¹⁷³ The average size of the facilities that closed was under 100 beds.¹⁷⁴ The average size of the facilities that survived approached 150 beds.¹⁷⁵

Some studies have found a positive relationship between nursing home size and facility financial status.¹⁷⁶ Larger facilities may be able to exploit economies of scale and thus make them more financially viable.¹⁷⁷ Since, as discussed below, financial instability played a major role in most of the nursing home closures, the smaller size of the homes that closed may have put them at greater risk of closure than the larger facilities that survived.

As noted previously, none of the homes that survived were part of a large multihome chain, and regulators perceived that the smaller corporations may have suffered and ultimately closed because they lacked the administrative skills and staff available to the larger corporations.¹⁷⁸ Moreover, the owners of the facilities that closed were generally not active in HCAM, their trade association, and may not have

172. All assertions are based on facility information contained in the relevant Health Care Financing Administration, Department of Health & Human Services Form 2567s reviewed by the author.

173. *Id.* See also CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T. OF HEALTH & HUMAN SERVS., NURSING HOME COMPARE, at <http://www.medicare.gov/NHCompare/home.asp> (last updated Dec. 2, 2003).

174. See *supra* note 172.

175. *Id.*

176. See Charlene Harrington et al., *Smoke Without Fire: California Nursing Home Closures, 1995–2001*, at 15 (2002) (unpublished manuscript, on file at Univ. of Cal., S. F.)

177. *Id.*

178. Interview with David Rector, *supra* note 151; Interview with Walt Wheeler, *supra* note 27.

received support or advice from other providers.¹⁷⁹ Indeed, some of the providers in the facilities that closed were unresponsive to MDCIS, and it appeared they simply did not play the licensure and certification game as effectively as other providers.¹⁸⁰

Several of the homes that survived did change owners at critical times in their licensing struggles, which was likely a key factor in their being able to improve conditions and convince regulators to give the facility another chance. None of the homes that closed acquired new owners to help bail them out of trouble, although unsuccessful attempts were made to sell at least one of the facilities.¹⁸¹

B. Financial Status

In six out of seven of the facilities that closed (86%), there was unmistakable, sometimes overwhelming, evidence in the MDCIS records reviewed and in interviews with MDCIS staff that the facility was in deep financial trouble.¹⁸² However, of the ten homes that remained open, in only three was there clear evidence of financial distress and MDCIS records revealed no obvious evidence of financial problems in half of the homes that remained open.¹⁸³

Perhaps the most appalling instance of financial distress appeared in the records regarding Applewood Manor. Between March 4, 1998, and September 15, 1998, the facility was cited five times for failure to provide necessary supplies or services, including having the telephone disconnected for nonpayment, failing to make payroll, and having to bring in food supplies on a day-to-day basis from the Lower Peninsula in a flat-bed truck because local vendors in the Upper Peninsula were unwilling to extend the facility any more credit.¹⁸⁴ In addition, suppliers refused further delivery of fuel oil used for heating, propane used for cooking, pharmaceuticals, nursing supplies, and miscellaneous items such as soda pop, ice, and shaving cream.¹⁸⁵

179. Interview with Walt Wheeler, *supra* note 27.

180. *Id.*

181. *Id.*

182. *See supra* note 172.

183. *Id.*

184. *See, e.g.*, HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, APPLEWOOD MANOR, at 1-2, 5 (Mar. 4, 1998) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, APPLEWOOD MANOR (Mar. 4, 1998)].

185. *Id.*

Belle Woods also had indisputable evidence of overwhelming financial crisis and mismanagement.¹⁸⁶ The MDCIS licensing officer for that facility received one to three calls per week over a period of months from vendors who were not being paid and some of whom were allegedly owed more than \$100,000.¹⁸⁷ Both the gas and phone companies threatened to cut off services after bills were not paid for a period of two years.¹⁸⁸ Among the vendors and service providers who withdrew for nonpayment were the temporary manager, several pool staff agencies, the ambulance company, the pharmacy, the rehabilitation services provider, and the laboratory that serviced the facility.¹⁸⁹ It was also discovered that although the facility had been withholding required deductions from employees' pay checks, it had not made the corresponding payments to the Social Security Administration or FICA and had failed to forward child support payments it withheld and health insurance premiums.¹⁹⁰ As a result of Belle Woods's financial mismanagement, allegations of fraud were made against the owner.¹⁹¹

At White Oak Manor, owned by the same provider as Applewood Manor, there were similar clear examples of financial distress. For instance, four months before it closed, MDCIS reported that White Oak's pay checks had bounced, food vendors were providing food on a cash only basis, and employees were using their own money to purchase food.¹⁹² Shortly before closure, the phone was disconnected due to nonpayment although this development was cited only at the C level.¹⁹³ Moreover, the home was in a state of gross disrepair, and nei-

186. WOOD, *supra* note 13, at 11.

187. *See generally id.* at 59; MICH. DEP'T OF CONSUMER & INDUS. SERVS., FACILITY LOG, BELLE WOODS CONTINUING CARE CENTER (Dec. 26, 1996 to Oct. 29, 1999) [hereinafter FACILITY LOG, BELLE WOODS].

188. *See generally* WOOD, *supra* note 13, at 59; FACILITY LOG, BELLE WOODS, *supra* note 187.

189. *See generally* WOOD, *supra* note 13, at 59-60.

190. *See generally id.*

191. *Id.*

192. HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, WHITE OAK MANOR (Aug. 14, 1998) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, WHITE OAK MANOR (Aug. 14, 1998)].

193. HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, WHITE OAK MANOR (Jan. 8, 1999) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, WHITE OAK MANOR (Jan. 8, 1999)].

ther the little issues nor the bigger physical plant ones were appropriately addressed, perhaps because of lack of funding.

Venoy's financial crisis was clear because it filed for Chapter 11 Bankruptcy protection.¹⁹⁴ At L & L, there were unsubstantiated complaints about financial insolvency and the kind of problems—extreme shortage of linens and towels, leaking roof, no emergency power source, and problems related to the facility's handling of resident funds—that may likely have been the result of financial distress.¹⁹⁵ And at Broadstreet, an MDCIS official asserted that the Department intervened after the facility failed to make payroll.¹⁹⁶

Fewer of the homes that survived had indisputable evidence of financial distress in the MDCIS records reviewed. Two facilities did file for bankruptcy.¹⁹⁷ Moreover, surveyors documented that outside vendors were not being paid by one facility and cited another for long-standing physical plant and environmental problems, understaffing, insufficient linens, and allegations of insufficient food,¹⁹⁸ which may also have been an indication of financial difficulties. While the other six facilities that survived may have suffered from financial stress, the records reviewed provided no clear evidence that their problems resulted from economic factors.¹⁹⁹

194. Press Release, Michigan Department of Consumer & Industry Services, State Permanently Revokes Venoy Nursing Ctr. License (Aug. 20, 1998), http://www.michigan.gov/cis/0,1607,7-154-10573_11472-54094—M_1998_8,00.html.

195. See STATEMENT OF DEFICIENCIES, L & L NURSING CENTER (Oct. 2, 1998), *supra* note 57; HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, L & L (July 24, 1997) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, L & L NURSING CENTER (July 24, 1997)]. See also Mich. DEP'T OF COM., BUREAU OF HEALTH SYSTEMS, COMPLAINT INVESTIGATION RE L & L NURSING CENTER (Oct. 7, 1998) (on file with author); Mich. DEP'T OF COM., BUREAU OF HEALTH SYSTEMS, COMPLAINT INVESTIGATION RE L & L NURSING CENTER (Apr. 3, 1996).

196. E-mail from Michael Dankert, Director of the Division of Operation, BHS, MDCIS, to Alison Hirschel (July 1, 2002, 11:14:55 EST) (on file with *The Elder Law Journal*).

197. See Press Release, Michigan Department of Consumer & Industry Services, Nightingale West to Stay Open Under New Owner (Mar. 3, 2000) (asserting that “[t]he transfer of Nightingale West to its new owner preceded the bankruptcy filing by its former owners that could have resulted in closure of the facility”), available at http://www.michigan.gov/cis/0,1607,7-154-10573_11472-50754—M_2000_3,00.html; see also *Woodfield Manor, Inc.*, NAT'L BANKR. REP., Mar. 25, 1999, at 19, available at 3/25/99 ANNBR 19 (Westlaw) (identifying Woodfield Manor, Inc. as filing for Chapter 11 Bankruptcy).

198. See Compiled Facility Survey Data on Roosevelt Park Nursing Home and St. James Nursing Center, 1997–2000 (on file with author).

199. See *id.*

Although financial crises have an obvious and often devastating effect on residents and may make closure inevitable, MDCIS has surprisingly little information about facilities' financial condition. Surveyors have no training in accounting or financial management and do not generally audit financial records.²⁰⁰ While facilities are required to submit financial information to the Michigan Department of Community Health, the state Medicaid agency, and to CMS, that information is not routinely shared with MDCIS and, even if MDCIS were to request financial information from the other agencies, the data may be quite outdated by the time it is made available to them.²⁰¹ Even overwhelming evidence of serious financial distress does not automatically trigger any increased oversight of the facility.²⁰² In fact, facilities are not even required to report to MDCIS when they file for bankruptcy²⁰³ and much of MDCIS's perceptions of a facility's financial situation appears to come from conjecture, industry gossip, or informal communications with facility staff, residents, families or advocates.²⁰⁴ And, while HCFA did require state survey agencies to track more carefully facilities that belonged to chains that had filed for bankruptcy,²⁰⁵ the state had no similar mechanism for increased scrutiny of other facilities in bankruptcy.²⁰⁶

200. MICH. DEP'T OF CIVIL SERV., HEALTH CARE SURVEYOR, http://www.michigan.gov/documents/HealthCareSurveyor_12713_7.pdf (Apr. 8, 2003) (providing a list of qualifications of health care facilities' surveyors not including the requirement of training in accounting or financial management).

201. Telephone Interview with Gwen Michel and Marilyn Samuels, *supra* note 52.

202. *Id.*

203. Interview with Walt Wheeler, *supra* note 27.

204. *Id.*

205. Michael Dankert, Chief of Operations for the Bureau of Health Systems at MDCIS, explained:

CMS requires additional oversight on [nursing home] chains in bankruptcy. CMS requires us to submit a chain monitoring log monthly. The actual method of oversight is at our discretion. It can be an on-site visit or a phone call for status, or contact with Ombudsman who has visited facility. The protocol isn't specific about the frequency of contact—it depends on overall communication with facility, general sense of how closely facility needs to be monitored, whether we have complaint investigations between standard surveys.

E-mail from Michael Dankert, BHS, MDCIS, to Alison Hirschel (July 9, 2002, 12:26:50 EST) (on file with The Elder Law Journal).

206. *Id.*

C. Environmental and Physical Plant Problems

All of the homes that were closed were cited for repeated, significant physical plant problems or, at the very least, striking environmental problems such as widespread dirty build-up on floors, leaky faucets, odors, loose tiles, or seepage from the toilets.²⁰⁷ A number of the homes had repeated Life Safety Code violations for safety hazards.²⁰⁸

In the case of both Venoy Nursing Center and White Oak Manor, the structural problems were so daunting that, although they had not been cited at a very high level during surveys, they played a significant role in the urgent decision to close the homes.²⁰⁹ For example, when a roofing expert checked the roof at Venoy shortly before the residents were transferred out, he noted extensive damage to the existing roof, asserted that the roof might blow off during a storm, and observed that it was rotting and creating a foul odor.²¹⁰ The temporary manager elaborated on the consequences of the roof problems, asserting that extensive water leakage occurred in the facility when it rained and that the water damaged the walls, covered many of the floors, and created a stench which she described as “a mixture of dead skunk, rotted meat and urine. It brought tears to your eyes.”²¹¹

At White Oak Manor, the facility was cited for having holes in the walls and numerous other physical plant problems.²¹² The facility’s final demise arose when an electrical fire in January 1999 spurred an inspection by the Office of Fire Safety and the County Electrical Inspector.²¹³ That inspection revealed imminent fire safety problems and immediate risk to life and property due to numerous electrical

207. See, e.g., STATEMENT OF DEFICIENCIES, WHITE OAK MANOR (Jan. 5, 1999), *supra* note 7.

208. See, e.g., *id.*

209. See *In re Venoy Nursing Ctr. v. Bureau of Health Sys.*, No. 98-0310N, at 7–8 (Mich. Dep’t of Consumer & Indus. Servs. Aug. 17, 1998) (proposal for decision) [hereinafter *Venoy Proposal for Decision*] (citing Respondent’s Exhibit 4, Attachment D, “Roof Inspection Report of the Nursing Home,” prepared by Testing Engineers and Consultants, Inc. of Troy, Michigan (May 5, 1998)).

210. *Id.* at 2, 7–8.

211. *Id.* at 6 (citing the testimony of Pat Price, temporary manager of the facility, during a May 15, 1998, hearing pursuant to the facility’s Chapter 11 Bankruptcy proceedings).

212. See, e.g., STATEMENT OF DEFICIENCIES, WHITE OAK MANOR (Jan. 5, 1999), *supra* note 7.

213. MICH. DEP’T OF CONSUMER & INDUS. SERVS., FIRE SAFETY PROBLEMS FORCE CLOSURE OF WHITE OAK MANOR (Jan. 12, 1999), http://www.michigan.gov/cis/0,1607,7-154-10573_11472-52444—M_1999_1,00.html.

code violations.²¹⁴ On January 8, 1999, the Electrical Inspector determined the facility would have to be completely rewired before approval could be granted for continued occupancy of the building.²¹⁵ A fire watch was instituted immediately, and the facility's license was revoked effective January 12, 1999.²¹⁶

Similarly, in the year that it was forced to close, L & L Nursing Center was given an *L* level citation, the highest level of immediate jeopardy violation, because it lacked an emergency power source.²¹⁷ Surveyors noticed a wall buckling at Lakeland Convalescent Center and roof leaks there and at Broadstreet Nursing Home, L & L, as well as Venoy.²¹⁸ At least three of the homes were repeatedly cited for housing residents in rooms that did not meet the minimum dimensions for nursing home bedrooms, for housing five residents in a single room, and for other long-term and serious building flaws.²¹⁹ Applewood Manor repeatedly promised to embark on a building plan to correct structural problems but was never able to do so.²²⁰ Belle Woods Continuing Care Center's appearance was dilapidated, depressing, and needed significant capital improvements that were never completed.²²¹

214. *Id.*

215. *Id.*

216. *Id.*

217. STATEMENT OF DEFICIENCIES, L & L NURSING CENTER (Oct. 2, 1998), *supra* note 57.

218. *See In re Venoy Nursing Ctr. v. Bureau of Health Sys.*, No. 98-0310, at 3 (Mich. Dep't of Consumer & Indus. Servs. Aug. 18, 1998) (final order) [hereinafter Venoy Final Order] (citing administrative law judge's findings that Venoy Nursing Center's roof was defective); *see also* HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, BROADSTREET NURSING HOME (Feb. 14, 2000) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, BROADSTREET NURSING HOME (Feb. 14, 2000)].

219. *See, e.g.*, STATEMENT OF DEFICIENCIES, L & L NURSING CENTER (July 24, 1997), *supra* note 195; HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, WHITE OAK MANOR (Sept. 22, 1997) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, WHITE OAK MANOR (Sept. 22, 1997)]; HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, APPLE WOOD MANOR (Jan. 28, 1998) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, APPLEWOOD MANOR (Jan. 28, 1998)].

220. *In re Applewood Manor, Inc. v. Bureau of Health Sys.*, No. 99-0330, Attachs. F, G (Mich. Dep't of Consumer & Indus. Servs. Mar. 5, 1999) (emergency license revocation and correction notice order) (stating that Applewood Manor not in compliance with building plan).

221. Personal observation of author during on-site visits in February 1999. *See also* HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, BELLE WOODS

Among the ten facilities that survived, only St. James Nursing Center, owned until the summer of 1998 by the same individual who owned Venoy, appeared to have a similar environmental and physical plant history to the homes that closed.²²² In 1997, it was the site of an apparent electrical fire requiring evacuation of the third floor.²²³ Its elevator was out of service for months because it was unsafe.²²⁴ Its heating, air conditioning, electrical system, and ventilation were all deemed to be hazardous.²²⁵ It also suffered leaks and was cited for soiled floors, broken equipment, rusty appliances, and debris.²²⁶ And, Nightingale West, although it lacked the dangerous conditions evident in so many facilities that closed, was repeatedly cited for having resident rooms that failed to meet the minimum required dimensions, for housing five residents in a single room, and for environmental problems such as being “grossly soiled,” having peeling paint, rusty equipment, odors, overflowing garbage, and leaky pipes.²²⁷ The remaining homes that survived did not appear to be cited for the same level of significant environmental and physical plant problems.²²⁸ While the surveys still painted a picture in many facilities of negligent maintenance and unappealing living conditions, the violations appeared, for the most part, to be more shameful and distasteful than imminently dangerous.²²⁹

CONTINUING CARE CENTER (Feb. 24, 1998) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, BELLE WOODS (Feb. 24, 1998)]; HEALTH CARE FIN. ADMIN., DEP’T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, BELLE WOODS CONTINUING CARE CENTER (Jan. 8, 1999) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, BELLE WOODS (Jan. 8, 1999)]; HEALTH CARE FIN. ADMIN., DEP’T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, BELLE WOODS CONTINUING CARE CENTER (Oct. 2, 1999) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, BELLE WOODS (Oct. 2, 1999)].

222. See St. James Nursing Center Survey Data, 1997–2000 (on file with author).

223. *Id.*

224. *Id.*

225. See HEALTH CARE FIN. ADMIN., DEP’T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, ST. JAMES NURSING CENTER (Oct. 22, 1998) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, ST. JAMES NURSING CENTER (Oct. 22, 1998)].

226. See HEALTH CARE FIN. ADMIN., DEP’T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, ST. JAMES NURSING CENTER (Feb. 25, 2000) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, ST. JAMES NURSING CENTER (Feb. 25, 2000)].

227. See Nightingale West Survey Data, 1997–2000 (on file with author).

228. See Compiled Facility Survey Data, 1997–2000 (on file with author).

229. See *id.*

In the majority of cases, physical plant and environmental violations were cited at the *B* through *E* levels, indicating the problems were not considered to cause actual harm and, for the *B* and *C* level cites, not even to have the potential to cause actual harm.²³⁰ Thus, these citations may have gotten less attention than citations at higher levels despite their obvious impact on residents' quality of life and their potential impact on residents' safety and the facilities' ultimate survival. Moreover, although annual Life Safety Code evaluations were performed on every facility, issues like leaky roofs could not be properly assessed by surveyors who had neither the expertise nor the opportunity to evaluate them.²³¹ Indeed, although Venoy's serious roof problems had been noted for at least a couple of years prior to its closure, MDCIS did not obtain an expert evaluation of the deplorable condition of the roof until ten days before the facility was forced to close and long after it had begun to cause flooding in the facility, a dreadful odor, and real danger to residents.²³² Thus, while surveyors cite facilities for the consequences of physical plant problems such as leaks that might cause safety hazards, the extent and potential future impact of these problems may never be properly evaluated.

Obviously, continuing physical plant problems are likely the consequence of, as well as an indicator of, significant financial distress or an owner with a callous disregard for residents' well-being. Facilities that fail to correct physical plant and environmental problems may not have the funds to do so, as appeared to be the case in most of the homes that closed. Alternatively, these facilities may lack desire to provide anything more to residents than the very minimum required to remain open. In either case, these continuing and serious problems should be a red flag to regulators and advocates that residents are at real risk, even if the problems themselves are considered to involve relatively low levels of citations.

230. *Id.* See also GAO, ADDITIONAL STEPS NEEDED, *supra* note 92, at 8 tbl.2, 10 tbl.3 (providing statistical data supporting the proposition that the majority of nursing homes studied had little or no potential for harm).

231. See Environmental and Physical Plant Problems Survey Data, 1997–2000 (on file with author).

232. Venoy Proposal for Decision, *supra* note 209, at 6.

D. Legal Interventions

Facilities' most common form of legal action is to appeal citations through the IDR system.²³³ Some facilities engage in other legal tactics including filing litigation in state or federal court, having a lawyer contact MDCIS or HCFA officials informally on the facility's behalf, or attempting to use bankruptcy proceedings to affect the outcome of survey and enforcement efforts.²³⁴ Three of the seven homes that closed appeared not to have utilized any of these strategies in responding to their licensing difficulties during the period reviewed.²³⁵ The remaining four homes that closed engaged in limited IDR appeals or short-term and very circumscribed legal efforts.²³⁶ Some failed even to appear at the administrative hearings regarding their license revocations.²³⁷

Except for St. James, which looks in many respects more like the homes that were forced to close, all of the homes that survived engaged in some IDR appeals or litigation during the period reviewed.²³⁸ Unlike the homes that closed, some of the homes that survived were quite aggressive in responding to survey and enforcement efforts.²³⁹ Heartland Manor, for example, pursued extremely energetic tactics and was represented by one of the most determined and aggressive industry lawyers.²⁴⁰ She requested IDR on all cites in some surveys, corresponded frequently with MDCIS, challenged the MDCIS notice and remedies, and alleged that her client had a fear of reprisal.²⁴¹ In fact, the facility insisted on having IDR appeals heard in another state.²⁴² West Wood of Niles filed suit in federal court to enjoin termination of the facility, which resulted in a settlement agreement.²⁴³ Nevertheless, the facility was ultimately terminated.

The facilities that closed might have failed to pursue legal strategies because, given their dire financial straits, they simply could not

233. See generally E-mail from Michael Dankert, *supra* note 16.

234. See Legal Interventions Survey Data, 1997–2000 (on file with author).

235. See Venoy Final Order, *supra* note 218, at 2 (stating that Venoy Nursing Center failed to appear for administrative hearing).

236. See Legal Interventions Survey Data, 1997–2000 (on file with author).

237. See Venoy Final Order, *supra* note 218, at 2 (stating that Venoy Nursing Center failed to appear for administrative hearing).

238. See Legal Interventions Survey Data, 1997–2000 (on file with author).

239. See generally E-mail from Michael Dankert, *supra* note 141.

240. *Id.*

241. *Id.*

242. *Id.*

243. *Id.*

afford to do so. Moreover, because the homes that closed were owned by smaller providers than most of the homes that survived, they may have lacked the sophistication to hire knowledgeable attorneys and engage in complex litigation. It is not clear, however, whether the more aggressive legal strategies attempted by some of the homes that survived played a role in keeping those facilities open, especially since many of the appeals were ultimately unsuccessful.²⁴⁴ They may, however, have bought the facilities time in which to correct their deficiencies and might have discouraged, intimidated, or simply worn out state regulators.

E. Staffing

All of the facilities that closed were cited for staffing issues during the period reviewed.²⁴⁵ Applewood and White Oak were cited for failing to fill managerial and professional staff positions and Lakeland received an *L* level citation just before closure when the nurse who was supposed to be on duty at the facility was found by surveyors across the street drinking malt liquor.²⁴⁶ The other four facilities were all cited for failing to meet Michigan's minimum nurse staffing requirements²⁴⁷ or minimum nursing needs of residents.²⁴⁸

244. *Id.*

245. *See, e.g.*, HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, APPLEWOOD MANOR (1999) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, APPLEWOOD MANOR (1999)]; HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, FOUR SEASONS NURSING CENTER (Dec. 20, 2000) (on file with author); HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, FOUR SEASONS NURSING CENTER (Nov. 17, 2000) (on file with author); STATEMENT OF DEFICIENCIES, FOUR SEASONS (Sept. 15, 2000), *supra* note 60.

246. STATEMENT OF DEFICIENCIES, APPLEWOOD MANOR (1999), *supra* note 245.

247. MICH. COMP. LAWS ANN. § 333.21720a(2) (West 2001) provides:

A nursing home shall employ nursing personnel sufficient to provide continuous 24-hour nursing care and services sufficient to meet the needs of each patient in the nursing home. . . . A licensee shall maintain a nursing home staff sufficient to provide not less than 2.25 hours of nursing care by employed nursing care personnel per patient per day. The ratio of patients to nursing care personnel during a morning shift shall not exceed 8 patients to 1 nursing care personnel; the ratio of patients to nursing care personnel during an afternoon shift shall not exceed 12 patients to 1 nursing care personnel; and the ratio of patients to nursing care personnel during a nighttime shift shall not exceed 15 patients to 1 nursing care personnel and there shall be sufficient nursing care personnel available on duty to assure coverage for patients at all times during the shift.

Of the homes that survived, the majority, but not all, received cites for insufficient staff.²⁴⁹ Tendercare Clare received a K level cite for serious understaffing, and West Wood was cited on one occasion for having only one nursing assistant to care for twenty-five residents. Interestingly, the three homes that were not cited for understaffing were among the homes in which the records revealed no evidence of financial distress.²⁵⁰ These homes also had no serious physical plant or environmental citations.²⁵¹

Staffing is evaluated through surveyors' observations and document reviews, as well as through quarterly reports submitted by nursing homes to MDCIS.²⁵² These reports are supposed to document the facility's staffing on a minimum of seven days selected by MDCIS during the previous quarter.²⁵³ Because these reports are not generally audited, however, they may be unreliable. Nevertheless, in the reports available, most of the seventeen troubled homes—both those that closed and those that remained open—reported staffing levels below the state average in the majority of their reports.²⁵⁴ However, a higher percentage of facilities that closed reported above average staffing during the periods under review than was reported by the facilities that survived.²⁵⁵

Occasionally, facilities reported exceptionally high staffing levels. For example, Heartland Manor reported having staffing during the third quarter of 2000 of 9.8 hours per resident per day, more than three times the state average during that period, while Lakeland reported staffing of 5.78 hours per resident per day in the third quarter

This is significantly less than the 4.1 hours of nursing care that a recent federal study determined was the minimum necessary to meet residents' basic needs. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., APPROPRIATENESS OF MINIMUM NURSE STAFFING RATIOS IN NURSING HOMES, REPORT TO CONGRESS 1-6 (Dec. 2001), <http://www.cms.gov/medicaid/reports/rp1201-1.pdf>.

248. See Legal Interventions Survey Data, 1997-2000 (on file with author).

249. *Id.*

250. *Id.*

251. *Id.*

252. See MICH. ADMIN. CODE r. 325.20704 (1999); COMPLAINT INVESTIGATION MANUAL, *supra* note 79, pt. 4, at 10.

253. See MICH. ADMIN. CODE r. 325.20704.

254. See, e.g., DIV. OF LICENSING & CERTIFICATION, MICH. DEP'T OF CONSUMER & INDUS. SERVS., OWNERSHIP: QUARTERLY STAFFING BED UTILIZATION RATIOS REPORT (3d Quarter 1998); *id.* (3d Quarter 1999); *id.* (3d Quarter 2000).

255. See, e.g., sources cited *supra* note 254.

of 1998, more than 50% above the state average.²⁵⁶ The extremely high staffing reported by some of the facilities, if accurate, may be aberrations due to a temporarily reduced resident census in the facilities resulting from bans on admission or readmissions.²⁵⁷

Records were not available to gauge the degree of staff-turnover among nursing assistants and other direct care staff at the facilities. However, staff of MPHI confirmed that, contrary to expectations, some of the most troubled facilities had relatively stable staffing.²⁵⁸ Unfortunately, long-standing staff in those facilities may have demonstrated long-standing incompetence and provided inadequate supervision and guidance to newer employees, thus contributing to the continuing licensing problems and “yo-yo” compliance many facilities demonstrated.²⁵⁹

All of the homes experienced significant turnover in their top administrative staff, which likely contributed to their inability to achieve and maintain compliance with state and federal requirements.²⁶⁰ For example, between January 1, 1996, and December 31, 2000, West Wood of Niles had eleven administrators and eleven directors of nursing and Four Seasons had five administrators and thirteen directors of nursing.²⁶¹ Belle Woods had seven administrators and five directors of nursing between March 1996 and its closure in October 1999.²⁶² While it intuitively appears that this turnover would increase facility instability, the fact that there was considerable turnover of top administrative staff does not distinguish the homes that closed from the ones that survived or the seventeen troubled facilities from many other facilities across the state with far better licensing histories.²⁶³

256. See DIV. OF LICENSING & CERTIFICATION, *supra* note 254, (3d Quarter 2000) at 3; see also *id.* (3d Quarter 1998) at 1.

257. For example, if a facility had a ban on admissions and readmissions, the resident census might have declined substantially. If, however, facilities chose to retain nursing staff in the hope that they would be able to fill their beds again in the future or because significant attention was required to address facility citations and the remaining residents' needs, the staff/resident ratios for that period would appear unusually high but not necessarily connote a consistent commitment to appropriate staffing.

258. See, e.g., sources cited, *supra* note 254.

259. Interview with Beth Bacon, *supra* note 57.

260. Data was not available for Bloomfield Hills Nursing Center.

261. MICH. DEP'T OF CONSUMER & INDUS. SERVS., FACILITY ADMINISTRATOR REPORT (2001).

262. *Id.*

263. *Id.*

F. Repeat Serious Violations

All of the facilities had numerous serious citations throughout the period reviewed and had a variety of sanctions imposed.²⁶⁴ Many were cited for the same deficiencies on subsequent surveys.²⁶⁵ In no case did one egregious violation or isolated incident lead to the facility's difficulties. Many of the facilities were cited, sometimes on more than one occasion, for substandard quality of care and immediate jeopardy violations.²⁶⁶ While many surveys were only a few pages long and had only a handful of citations, in 1999, West Wood of Niles (formally known as Woodfield Manor) had thirty-three citations documented in a 70-page survey,²⁶⁷ while Nightingale West was cited for forty-nine violations in a 120-page survey.²⁶⁸

A very substantial number of all of the facilities' violations involved quality of care issues such as failure to monitor nutrition and hydration, poor medication management, inadequate attention to resident grooming and hygiene, failure to prevent the development of pressure sores, failure to supervise residents and prevent accidents and injuries, and failure to manage appropriately tube feedings or catheters.²⁶⁹ Many facilities were also cited for failure to properly assess residents, dietary violations, administrative failures, and environmental deficiencies.²⁷⁰ Some of the detailed descriptions of the cir-

264. See Compiled Facility Survey Data, 1997-2000 (on file with author).

265. See, e.g., STATEMENT OF DEFICIENCIES, FOUR SEASONS (Sept. 15, 2000), *supra* note 60.

266. See, e.g., HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, BELLE WOODS CONTINUING CARE CENTER (Oct. 23, 1999) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, BELLE WOODS (Oct. 23, 1999)]; STATEMENT OF DEFICIENCIES, BELLE WOODS (Jan. 8, 1999), *supra* note 221; HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, BELLE WOODS CONTINUING CARE CENTER (Sept. 14, 1998) (on file with author) [hereinafter STATEMENT OF DEFICIENCIES, BELLE WOODS (Sept. 14, 1998)].

267. See HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, WOODFIELD MANOR, INC. (Apr. 30, 1999) (on file with author).

268. See HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, NIGHTINGALE WEST NURSING HOME (Dec. 20, 1999) (on file with author).

269. See, e.g., STATEMENT OF DEFICIENCIES, BELLE WOODS (Jan. 8, 1999), *supra* note 221; HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, ROOSEVELT PARK NURSING CENTER (Aug. 30, 2000) (on file with author).

270. See, e.g., STATEMENT OF DEFICIENCIES, BELLE WOODS (Jan. 8, 1999), *supra* note 221.

cumstances leading to the issuance of the citation were exceedingly gruesome or heartbreakingly sad.²⁷¹

While only 20% of the homes that closed had surveys during the time reviewed with more than twenty citations, 80% of the facilities that remained open had twenty or more violations in at least one survey during the period reviewed in the study and many had multiple surveys with more than twenty.²⁷² Moreover, many of these citations involved immediate jeopardy or other high-level violations. Thus, at least within the subset of very troubled homes, the number of violations—even very serious ones—does not appear in itself to be a good predictor of closure.

271. For example, at L & L, an eighty-three-year-old resident with a diagnosis of dementia and schizophrenia; a history of falls, elopements, and attempts to hide in the bath tub; and a care plan that emphasized the need for close supervision, died after being found submerged, fully clothed, in a bath tub filled with hot water. When she was examined, staff observed bleeding from a head wound and noted that the skin was peeling off her lower extremities and buttocks. See STATEMENT OF DEFICIENCIES, L & L NURSING CENTER (OCT. 2, 1998), *supra* note 57. A few days later, surveyors substantiated a complaint that a cognitively impaired resident was raped by a visitor and that another confused resident was sexually assaulted by another resident in the facility. HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, L & L NURSING CENTER, INC. (OCT. 4, 1998) (on file with author). At Lakeland Convalescent Center, nursing assistants on a single day poured cold water on a resident allegedly to "calm" him, hit him with a plunger, beat him, dragged him by the legs to the stairway, kicked him in the back, used profanity when addressing him, and threw him fully clothed into a bath tub. Subsequently, the administrator kicked the resident and told him to get up. The resident was transferred to the emergency room of a local hospital the next day where he was observed to have bruises on his back, face, right hip, and right eyebrow, and facility records also noted scratches and other injuries. See HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, LAKELAND CONVALESCENT CENTER (Aug. 29, 1999) (on file with author). The facility received a K level citation for the incident and criminal charges were later filed against the administrator, two nursing assistants, and a nurse. At White Oak Manor, the wife of a dying resident begged to be called at any time of night if there was any change in his condition, and she had been given a beeper for that purpose. The resident and his wife had promised to hold each other at the time of death, and the resident had repeatedly requested not to be left alone. However, despite documenting clear signs of the resident's deterioration, the facility failed to contact the resident's spouse until staff notified her of her husband's death. The resident's wife expressed great distress at not being able to be with her husband when he died. See HEALTH CARE FIN. ADMIN., DEP'T OF HEALTH & HUMAN SERVS., FORM 2567, STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION, WHITE OAK MANOR (June 11, 1998) (on file with author). The facility received a G level citation.

272. See Compiled Facility Survey Data, 1997–2000 (on file with author).

G. Intermediate Sanctions, Remediation Efforts, and Terminations

Virtually all of the facilities that closed and that remained open were subjected to a vast array of intermediate sanctions including denial of payment for new admissions, bans on admission, civil monetary penalties, nurse aide lock-outs, state monitoring, mandatory clinical advisors, and directed in-service trainings or directed plans of correction.²⁷³ Many facilities received these sanctions in multiple years.²⁷⁴ No significant difference appeared between the sanctions imposed on homes that closed and on those that survived.²⁷⁵ During the period of the study, however, as noted earlier, after the creation of the Collaborative Remediation Project, MDCIS substantially reduced the number of civil monetary penalties it imposed and increased more than tenfold the number of directed plans of correction it required.²⁷⁶

Although termination from the Medicaid program is an extremely serious sanction that often results in nursing home closures,²⁷⁷ it did not precipitate the closure of any facilities in the study.²⁷⁸ Indeed, several of the homes that survived were terminated, sometimes more than once, remained open, and were eventually permitted to re-enter the Medicaid program.²⁷⁹

Despite the imposition of a multitude of intermediate sanctions, collaborative remediation efforts, and some terminations, many of the troubled facilities that survived continued to have poor surveys even after the period of the study.²⁸⁰ St. James, for example, had more than twenty cites in 1998, 1999, and 2001, and the vast majority of facilities that survived continued to be cited for more violations than the state average in at least some of the surveys conducted after the imposition of the temporary manager.²⁸¹

273. *Id.*

274. *See, e.g.*, FACILITY LOG, BELLE WOODS, *supra* note 187; DEP'T. OF CONSUMER & INDUS. SERVS., FACILITY LOG, BLOOMFIELD HILLS NURSING CENTER (2000).

275. *See* Compiled Facility Survey Data, 1997–2000 (on file with author).

276. *See* discussion *supra* notes 134–37 and accompanying text.

277. *See* WOOD, *supra* note 13, at 13.

278. *Id.* at 17; *see also* Compiled Facility Survey Data, 1997–2000 (on file with author).

279. *See generally* FACILITY LOG, HEARTLAND MANOR, *supra* note 115.

280. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 247. (In order to access the information cited, conduct a search of all Michigan nursing homes and select the homes of interest from the list provided.)

281. *Id.*

VIII. Recommendations and Conclusion

1. *Regulators must track a broader array of information on all facilities to identify risks, determine appropriate interventions, and protect residents.*

The Nursing Home Reform Law requires regulators to have an intense focus on resident outcomes.²⁸² Although it is entirely appropriate and exceedingly important that surveyors concentrate on the quality of residents' care and life, the survey and enforcement system's primary focus on these factors results in regulators virtually ignoring or only haphazardly and belatedly addressing external factors, beyond the residents' documented experiences, which have a dramatic impact on the viability of the facility.²⁸³ As demonstrated above, regulators cannot do their job effectively unless they are able to obtain and consider information regarding a wider array of factors that affect facility outcomes.²⁸⁴

Many observers agree that MDCIS needs more information to assist it in its regulatory function.²⁸⁵ Beth Bacon, former Director of MPHI's Collaborative Remediation Project, suggests that MDCIS conduct periodic viability studies of all facilities to determine existing or potential risks and threats to residents and facility survival.²⁸⁶ This research suggests that these studies must include, at a minimum, information regarding financial stability, size and ownership, and physical plant condition. Because more intangible factors such as the sophistication and attitude of providers can have an important impact in facilities' fates, they should also be noted in the viability study. Depending on regulators' concerns about specific facility weaknesses, individuals with diverse expertise, from financial analysts and engineers or architects to those skilled at evaluating staffing and medical and nursing criteria, can be asked to contribute information to the facility's viability profile. Relevant financial information that facilities are already required to submit to CMS and MDCH must be shared with MDCIS promptly and in a form that is easy for MDCIS to understand and utilize.

282. 42 U.S.C. §§ 1395i-3(g)(2)(A)(ii), 1396r(g)(2)(A)(ii) (2000); 42 C.F.R. § 488.305(a) (2002).

283. *See supra* text accompanying notes 72–80.

284. *Id.*

285. *See, e.g.*, Interview with Beth Bacon, *supra* note 57.

286. *Id.*

Once all relevant information is gathered, the viability profiles should paint a detailed picture of the facility and suggest, not just what current flaws exist, but where there is the greatest potential for problems in the future.²⁸⁷ If a viability study reveals that a facility has little chance for long-term survival and should not be saved, MDCIS can have frank conversations with the owners and work with them to arrange a well-planned and orderly voluntary closure. If a viability study reveals significant problems that have not otherwise been publicly identified, release of the information could cause increased facility instability if staff, residents, or prospective buyers flee fearing a potential closure. Moreover, the nursing home industry would likely strongly resist any effort at greater oversight or reporting requirements and the release of sensitive or unflattering facility information. Regulators have also expressed concerns that it would be harder to obtain financial information about facilities belonging to large out-of-state chains.²⁸⁸ Because such information is crucial to regulating the homes appropriately, however, nursing homes must be required to disclose it as a condition of doing business as a nursing facility in Michigan.

2. *Regulators must develop more useful predictive tools that take into account a much broader array of factors than current tools.*

As demonstrated above, current tools used by state and federal regulators to identify homes requiring additional scrutiny and swift intervention focus on too narrow a range of factors and thus are unreliable and slow in predicting which homes are at greatest risk of closure and in which homes residents have the greatest need for protection. Better predictive tools must be developed and utilized.

Although periodic viability profiles can paint a general picture of all facilities, predictive tools using information gathered from the viability profiles as well as surveys and other sources can identify facilities on an ongoing basis that require immediate investigation or in-

287. For example, at the time the viability study is prepared, a facility might have failed to pay only one or two vendors. The viability study could evaluate whether these financial failings resulted from simple administrative error or are indicative of a potential financial crisis. Similarly, the facility might have been cited at the time of the viability study for some relatively minor Life Safety Code violations. Engineers or other experts could evaluate those issues to determine whether if left unaddressed, they may become significant hazards and to review the facility's history in addressing physical plant deficiencies.

288. Interview with Walt Wheeler, *supra* note 27.

tervention. Results should be tabulated at least quarterly and can be the subject of periodic meetings of MDCIS staff.

Because the most obvious red flag of a facility likely to fail is financial instability, predictive tools must factor in reliable and current information about a facility's financial status. Other indicia of a home's vulnerability, such as facility size, significant and long-standing physical plant problems, failure to pay vendors or staff, shortages of supplies and food, and staffing deficiencies, must also be considered. Once MDCIS develops these tools, it must have procedures in place to respond to the homes identified as being at risk. Certain predictive scores or outcomes can be considered triggers for increased oversight, immediate intervention, notice to facilities, or, if appropriate, notice to long-term care ombudsman.

3. *Further study is required to determine the role and effectiveness of the Collaborative Remediation Project and how early intervention efforts can protect residents and reduce the necessity of closures.*

While it is beyond the scope of this project to evaluate the effectiveness of the Collaborative Remediation Project, Michigan has made remediation the focal point of its enforcement efforts for seriously troubled homes.²⁸⁹ The project appears to be unique and has even been noted with favor in a *New York Times* editorial.²⁹⁰ Some observers have already called for a temporary management demonstration project and lamented the infrequent use of temporary managers in other states.²⁹¹ Michigan's model might serve as a useful demonstration project and further study could reveal whether remediation can provide short-term and long-term improvements in seriously troubled facilities, thus reducing poor resident outcomes and the need for facility closures.

The results of this study do suggest, however, that to be effective, temporary managers and other remediators must be brought in early enough to have a chance to address significant problems before they become crises. Use of viability studies and predictive tools may suggest the advisability of assigning remediators to facilities far ear-

289. See NURSING HOME INITIATIVE, *supra* note 11, Tab 1 (referring to *MHPI Description and Resources*).

290. Editorial, *They Didn't Live So Long for This*, N.Y. TIMES, Apr. 26, 1999, at A20. But see *supra* notes 139-40 and accompanying text for concerns about collaboration as a key element of the enforcement system.

291. See, e.g., WOOD, *supra* note 13, at 51-52.

lier than is common in current regulatory practice. Moreover, temporary managers and other remediators must have the ability to address all factors that affect resident and facility outcomes.²⁹² Thus, temporary managers may have to bring in consultants with skills in accounting, engineering, and other areas to supplement their own knowledge of nursing home operations and clinical practices. Similarly, directed in-service trainings and other remediation functions may need to encompass a wider range of issues as owners and managers of troubled facilities may need as much assistance with administrative and financial functions as with issues posing a more immediate or obvious threat to quality of care or life.

4. *In case of facilities' financial collapse, funding must be available to hire temporary managers if they are determined effective, provide emergency supplies to residents, and ensure residents do not suffer.*

Facilities in this study that had severe financial difficulties put residents in enormous peril, sometimes over a period of many months, because they could not guarantee adequate supplies of food, pharmaceuticals, linens and diapers, sufficient staffing, or even continued service by utility companies.²⁹³ Moreover, facilities' unwillingness or inability to pay for collaborative remediation services resulted in the absence or cessation of those services at the very time when they might have been most needed.²⁹⁴ Many of these facilities had a long track record of failure, and no reason existed to believe they would manage to provide adequate care and services to residents in the midst of their financial crises.

As long as the state permits a nursing facility to remain open, however, the government has the obligation to ensure residents receive the most basic care and services. Therefore, funding must be available as soon as residents begin to suffer significantly as a result of the facility's economic troubles. These funds can pay for temporary managers or other service providers or for urgently needed supplies or staff. Repayment can be sought from a facility using standard legal procedures or withheld from future reimbursement due to the facility and sanctions for permitting the residents to be at the brink of such

292. See generally *id.* at 31.

293. E.g., STATEMENT OF DEFICIENCIES, WHITE OAK MANOR (Jan. 5, 1999), *supra* note 7.

294. E-mail from Michael Dankert, Director of the Division of Operations, BHS, MDCIS, to Alison Hirschel (Oct. 30, 2003, 09:25:13 EST) (on file with author).

peril should be severe. During the period in which government funding is necessary to provide for the residents' safety and the continued operation of the facility, negotiations can take place with the goal of selling the facility or, as a last resort, of closing it with a careful plan for the relocation of the residents.

5. *Additional exploration is needed on how failing providers can be encouraged to sell, and what role state licensing agencies can play in facilitating the change of ownership.*

As noted above, in the absence of irreparable and imminently dangerous physical plant deterioration, it is almost always preferable to bring in new, more competent, or financially sound ownership than to force residents to move out. However, regulators tend to have very limited involvement in these efforts, often alleging they have limited ability to become involved in private business transactions.²⁹⁵

Nevertheless, a regulatory agency could take both informal and formal action to facilitate advantageous changes in ownership. Informally, MDCIS staff could strongly encourage poor providers to sell; gather and share information about and with potential buyers and sellers; and assure potential purchasers of the Department's cooperation. Moreover, Michigan could amend its receivership statute so that, unlike the current provision,²⁹⁶ it could be used to transfer ownership or control of the facility promptly before license revocation or suspension occurs.²⁹⁷ In her study of nursing home terminations,²⁹⁸ Erica Wood suggests receivership should be used as an intermediate

295. Interview with Walt Wheeler, *supra* note 27.

296. MICH. COMP. LAWS ANN. §§ 333.21751, .21799(b) (West 2001).

297. Erica Wood, while acknowledging the close relationship between receivership and temporary management, identifies significant differences between the two remedies:

First, receivership is not a federal remedy, whereas temporary management is. Second, receivership requires a court order and features continuing judicial oversight, whereas temporary management may or may not. Third, receivership may allow for greater authority in managing a facility and taking financial control than temporary management. A state regulator observed that receivership "is a better option than temporary management because there is the authority of the court. It gives a better basis for both parties to understand boundaries and responsibilities and third party oversight, and [is] a way to resolve conflicts, whereas temporary management through an administrative appointment does not do this." Others find receivership more cumbersome, in that going to court is a significant obstacle to overcome.

WOOD, *supra* note 13, at 35.

298. *Id.*

sanction and asserts, “[t]riggers for receivership should be broadened beyond situations of closure, state licensure action, or immediate jeopardy to include instances where a facility is continually or repeatedly out of compliance, homes are financially unstable and at risk of bankruptcy, or residents need protection.”²⁹⁹

6. *If closure and resident relocation cannot be avoided, residents require far greater protection during the transition and follow-up after transfer.*

Even if viability studies were performed, better predictive tools were used, and early and appropriate interventions were imposed, some facilities will still close. In those unfortunate situations, residents require very strong protections to assure a safe and orderly discharge that minimizes the likelihood of transfer trauma.³⁰⁰ Although Michigan has an interagency protocol for nursing home closures involving MDCIS, the Family Independence Agency, and the Office of Services to the Aging,³⁰¹ the actual transfers of residents have still been highly problematic. An atmosphere of fear, anger, confusion, and panic has pervaded many facilities as news of the mandatory relocation spreads. Residents have been transferred to other substandard facilities, and inadequate information has been available to family and residents about the licensing history of the facilities to which they could be transferred. In many cases, little thought appears to have been given to the ability of the new facility to respond to the residents' needs; instead the focus appears to have been simply on bed availability, willingness of the facility to accept the residents' source of payment, location of the facility, and the speed with which the transfer can be arranged. Few residents were appropriately assessed for possible placement in the Home and Community Based waiver program or other community-based options. Ombudsman, who often are much more familiar with the advantages and disadvantages of other facilities and options than the local Family Independence Agency staff and who may know individual residents well, were only haphazardly involved in helping to arrange for the transfers.

Michigan regulations assert that transfer plans for residents transferred involuntarily should assure that the proposed new place-

299. *Id.* at 52.

300. *Id.* at 40.

301. STATE OF MICH. FAMILY INDEPENDENCE AGENCY, INTERAGENCY AGREEMENT FOR NURSING FACILITY CLOSURES (2001).

ment is appropriate for the residents' needs.³⁰² The resident, family, and legally responsible persons should be involved in the choice of facility to which the patient is to be transferred.³⁰³ At least one counseling session should be provided to each resident who is transferred.³⁰⁴ The resident should also have the opportunity to visit the proposed placement at least once (and such a visit may be waived only if the attending physician documents in the patient's clinical record that such a visit is medically contraindicated or if the resident, guardian, or resident representative determines, in writing, that it is not in the resident's best interests, in which case the resident must receive floor plans, photos, or other information to familiarize him or her with the new facility).³⁰⁵ Family members or other appropriate people may accompany the resident to the new placement, unless the resident requests otherwise.³⁰⁶ Moreover, MDCIS must approve a facility plan to effectuate the orderly and safe transfer or discharge of a resident.³⁰⁷ However, these important protections are rarely, if ever, extended to residents who are being discharged due to facility closures.³⁰⁸ In fact, the most basic logistics such as assuring the resident leaves with all his or her possessions, funds, medications, and medical records have often been neglected.³⁰⁹

Home closures involve mass relocations, and these transfers cannot be done appropriately without a carefully crafted plan, consistent information for residents and families, a reasonable time line that focuses on residents' needs, significant staff resources including those familiar with other options in the community, a careful assessment of each resident, appropriate staff assigned to create an individualized discharge plan for each resident, and prompt and ongoing follow-up with residents after transfer to assure their well-being.³¹⁰ If facility staff is already leaving or incompetent to care for residents before dis-

302. See MICH. ADMIN. CODE r. 325.20116(2)(g)(ii) (2001).

303. See *id.* r. 325.20116(2)(g)(iii).

304. *Id.* r. 325.20116(2)(g)(iv).

305. *Id.* r. 325.20116(2)(g)(v).

306. *Id.* r. 325.20116(2)(g)(vi).

307. *Id.* r. 325.20116(2)(f).

308. *Id.* r. 325.20116(4).

309. See SHERER MURTIASHAW, NAT'L LONG-TERM CARE OMBUDSMAN RESOURCE CTR., THE ROLE OF LONG-TERM CARE OMBUDSMAN IN NURSING HOME CLOSURES AND NATURAL DISASTERS 32, 38, 45 (2000) (recommending residents be kept aware of the status of their belongings and medical data during a move).

310. See Beirne et al., *supra* note 17, at 122; Manion & Rantz, *supra* note 17, at 109 tbl. 2.

charge, or if physical plant concerns necessitate prompt evacuation, additional safeguards and resources need to be available to assure as safe a discharge as possible.³¹¹ MDCIS orders homes to close to protect the home's residents; it therefore has an obligation to assure that the resultant transfers are the first step toward better protection of residents rather than exacerbating any trauma they have already suffered.

Undoubtedly, a performance closure represents a potential tragedy for the residents, a failure of the provider, and also, often, a failure of the survey and enforcement system to assure residents receive consistent quality care and quality of life in a safe environment.³¹² Moreover, many of the homes that managed to survive in this study hardly represent victories for residents and the enforcement system because the facilities often continued to be cited for multiple, serious problems after the imposition of a temporary manager and some may even remain at risk of ultimate closure.

This study demonstrates that factors such as financial crises and unsafe structures may be better predictors of ultimate closure than the mere number of serious citations which focus on more immediate resident outcomes. Only if state and federal survey and enforcement law and policy is changed to require regulators to gather, analyze and act on a far wider array of information that truly affect facilities' viability, will troubled homes that could be saved with early intervention or changes in management or ownership remain open. And only if these measures are taken will residents be protected from the unspeakable harm they sometimes suffer when homes decline and are forced to close.

311. See MURTIASHAW, *supra* note 309 (outlining the steps state and local ombudsman should take to plan for possible closures and to assist residents with forced relocations).

312. See *id.* at 19–20.