Survey Research

Governmental Efforts to Improve Quality of Care for Nursing Home Residents and to Protect Them from Mistreatment

A Survey of Federal and State Laws

Josephine Gittler, JD

ABSTRACT

There are many federal and state laws addressing, directly and indirectly, the quality of care provided to nursing home residents and the protection of residents from mistreatment. They include: (a) state laws that govern the licensing of nursing homes, (b) federal laws that govern the certification of nursing homes for participation in the Medicare and Medicaid programs, (c) elder abuse laws prohibiting mistreatment of older adults in nursing homes and other settings, (d) health care fraud abuse laws that are increasingly being used to combat the provision of substandard care to Medicare and Medicaid beneficiaries in nursing homes, and (e) laws that have established long-term care ombudsman programs to promote the health, safety, well-being, and rights of nursing home residents. While these laws are generally viewed as having improved the care and treatment of nursing home residents, much remains to be done, particularly with respect to the implementation of these laws.

The body of law related to the quality of care provided to nursing home residents and the protection of residents from mistreatment is large and complicated, and it includes both federal and state statutes and regulations. This article summarizes the results of a survey of these statutes and regulations. It also summarizes the results of a review of the literature regarding the implementation of these statutes and regulations. It is derived from a report prepared for the Nursing Home Collaborative (NHC), consisting of five Hartford Centers of Geriatric Nursing Excellence (HCGNEs) (Gittler, 2008). **Table 1** lists the sources consulted in the survey of statutes and regulations, and **Table 2** lists the sources consulted in the review of literature.

BACKGROUND

The NHC survey addressed five main kinds of laws:

- State licensing laws.
- Medicare/Medicaid certification laws.

Dr. Gittler is Wiley B. Rutledge Professor of Law, Professor of Health Management and Policy, Policy Director, The John A. Hartford Center of Geriatric Nursing Excellence, and Director, National Health Law and Policy Resource Center, The University of Iowa, Iowa City, Iowa.

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Address correspondence to Josephine Gittler, JD, Wiley B. Rutledge Professor of Law, 412 Boyd Law Building, The University of Iowa, Iowa City, IA 52242; e-mail: josephine-gittler@uiowa.edu.

TABLE 1

Sources Consulted for Survey of Laws

Statutes and Regulations	Sources Searched
FEDERAL	FEDERAL
• United States Code	• Law Library, College of Law, The University of Iowa
• United States Code Annotated	• Lexis/Nexis® database (electronic)
• United States Statutes at Large	• Westlaw® database (electronic)
• Code of Federal Regulations	• U.S. Code Collection
• Centers for Medicare & Medicaid Services, State Operations Manual	• Cornell University Law School (electronic)
	• Electronic Code of Federal Regulations
	• Centers for Medicare & Medicaid Services Web site
STATE	STATE
Arkansas	• Law Library, College of Law, The University of Iowa
• Arkansas Code	• Lexis/Nexis database (electronic)
• Arkansas Register	• Westlaw database (electronic)
California	• NH (Nursing Home) Regulations Plus (electronic database of federal and state nursing home regulations)
• West's Annotated California Code	• National Center on Elder Abuse Web site
• Deering's Annotated California Code (Health and Safety; Welfare and Institutions)	• National Citizen's Coalition for Nursing Home Reform Web site
• California Code of Regulations	• National Long Term Care Ombudsman Resource Center Web site
Iowa	
• Code of Iowa	
• West's Annotated Iowa Code	
• Iowa Administrative Code	
Oregon	
• Oregon Revised Statutes	
• Oregon Administrative Rules	
Pennsylvania	
• Pennsylvania Consolidated Statutes	
• Pennsylvania Consolidated Statutes Annotated	
• Pennsylvania Code	

- Elder abuse laws.
- Health care fraud and abuse laws.
- Long-term care ombudsman laws.

Because state licensing laws and Medicare/Medicaid certification laws are the basis for much of the regulation of nursing homes, the majority of this article examines these laws. The article also examines, albeit briefly, elder abuse laws, health care fraud and abuse laws, and long-term care ombudsman laws. Because the focus of the NHC survey was federal laws and state laws in Arkansas, California, Iowa, Pennsylvania, and Oregon—states in which the HCGNEs comprising the NHC are located—these are the focus of this article. (Please note that citations to the specific statutes and regulations referenced in this article can be found in the report from which the article is derived: Gittler [2008].)

STATE LICENSING LAWS AND MEDICARE/MEDICAID CERTIFICATION LAWS

The principal components of the legal framework for nursing home regulation are state licensing laws and Medicare/Medicaid certification laws. Nursing home licensing laws are defined for the purpose of this article as the state laws that govern the licensure of nursing homes, which is a prerequisite for their operation. Medicare/Medicaid certifi-

TABLE 2

Sources Consulted for Literature Review

Government
• U.S. Department of Health and Human Services
U.S. Administration on Aging Web site
Centers for Medicare & Medicaid Services Web site
Office of Inspector General Web site
• U.S. Congress
U.S. House of Representatives Web site
Government Accountability Office Web site
U.S. Senate Web site
Thomas (Library of Congress) Web site
Scholarly
• Google Scholar
• Lexis/Nexis database
• PubMed (including Medline)
• Public Affairs Information Services (PAIS)
• Westlaw database
Resource Centers and Clearinghouses, Foundations, and Advocacy Organizations
• AARP Policy and Research Web site
• Clearinghouse on Abuse and Neglect of the Elderly Web site and database
• The Commonwealth Fund Web site
• Henry J. Kaiser Family Foundation Web site
• National Center on Elder Abuse Web site
• National Citizen's Coalition on Nursing Home Reform Web site
• National Long Term Care Ombudsman Resource Center Web site
Other
• Google
• National Health Law and Policy Resource Center, College of Law, The University of Iowa

cation laws are defined for the purpose of this article as the federal laws that govern the certification of nursing homes for participation in the Medicare program, the Medicaid program, or both, without which they cannot receive payments from these programs.

Historical Perspective

Historically, the licensing of nursing homes has been a state prerogative and a matter of state law. Therefore, states were the original source of nursing home regulation through their licensing authority.

The Social Security Act Amendments of 1965 dramatically altered states' historical role in nursing home regulation (Gittler, 2008). This legislation created Title XVIII of the Social Security Act authorizing the Medicare program, the federal health insurance program for all individuals age 65 and older, and Title XIX authorizing the Medicaid program, the joint federal-state health insurance program for low-income individuals. The former pays for skilled nursing care for a limited time in a Medicare-certified facility, and the latter pays for long-term care in a Medicaid-certified facility. An estimated 95% of nursing homes are certified to participate in the Medicare program, the Medicaid program, or both (Fogge, 2007). In 2005, the Medicare and Medicaid programs accounted for 60% of nursing home expenditures, with the Medicaid program accounting for the majority (nearly 40%) of these expenditures (Catlin, Cowan, Heffler, Washington, & National Health Expenditure Accounts Team, 2007).

During the past several decades, the federal government has assumed an ever-larger role in the de facto regulation of nursing homes by conditioning their participation in the Medicare and Medicaid programs on their compliance with certain requirements. In the 1970s and 1980s, it became apparent that inadequate care of older adults and elder mistreatment were serious problems in nursing homes (Capitman, Leutz, Bishop, & Casler, 2004; Coleman, 1991; Walshe, 2001; Weiner, Freiman, & Brown, 2007). Thus, a 1986 Institute of Medicine (IOM) report declared that in many Medicare/Medicaid certified nursing homes, residents "receive very inadequate—sometimes shockingly deficient—care" and that "they also are likely to have their rights ignored or violated, and may even be subject to abuse" (IOM, Committee on Nursing Home Regulation, 1986, p. 3). Recognition of their plight led to the enactment of the Nursing Home Reform Act of 1987, as part of the Omnibus Budget Reconciliation Act of 1987 (Gittler, 2008). This landmark legislation brought about sweeping reforms in Medicare/Medicaid nursing home certification requirements, the monitoring of nursing homes for compliance with these requirements, and enforcement of these requirements.

Despite the current predominant role of the federal government in regulating nursing homes through Medicare/Medicaid certification requirements, these regulations set a floor, not a ceiling, for nursing home regulation. States retain independent power to regulate

nursing homes by virtue of their licensing authority, and state licensing requirements may be more stringent than requirements for Medicare/Medicaid certification.

Quality of Care Requirements

The Social Security Act's Medicare and Medicaid provisions and their implementing regulations pertaining to the certification of nursing homes for Medicare/Medicaid participation contain numerous substantive conditions (Gittler, 2008). These conditions encompass many aspects of nursing home care, staffing, operations, administration, and physical plant. Conditions related to the quality of care provided to nursing home residents are among the core certification requirements for Medicare/Medicaid participation.

The quality of care requirements revolve around resident outcomes, rather than facility capacities and characteristics. Their overall aim is to ensure each resident receives and each facility provides the necessary care and services "to attain or maintain the highest practicable physical, mental, and psychological well being" of the resident in accordance with the resident's comprehensive assessment and plan of care (42 U.S.C. § 1395i-3(b) (4); 42 U.S.C. § 1396r (b) (4); 42 C.F.R. § 483.25). They cover activities of daily living, vision and hearing, pressure sores, urinary incontinence, range of motion, mental and psychosocial functioning, nutrition, hydration, nasogastric tubes, special needs, unnecessary drugs and antipsychotic drugs, medication errors, and accidents. **Table 3** provides a description of each of these requirements. The central thrust of the quality of care requirements is to ensure a resident does not develop certain enumerated problems (e.g., malnutrition, dehydration, pressure ulcers) unless unavoidable due to the resident's clinical condition and to ensure a resident who does develop these problems receives appropriate care and services.

The quality of care requirements are closely tied to requirements for resident assessments and care plans. Facilities periodically must conduct a "comprehensive, accurate, standardized, reproducible" assessment of a resident's functional capacity and needs, using a standardized resident assessment instrument (42 U.S.C. § 1395i-3(b) (2); 42 U.S.C. § 1396r (b) (2); 42 C.F.R. § 483.20). On the basis of the resident's assessment, facilities must then develop a comprehensive care plan for the resident, which reflects the quality of care requirements in terms of the areas assessed and the needs addressed (Gittler, 2008).

In addition to Medicare/Medicaid certification requirements, nursing homes must meet and adhere to state licensing requirements. A recent analysis of state licensing regulations found that the California, Iowa, Oregon, and Pennsylvania regulations, as well as many other state regulations, have quality of care requirements that go beyond the federal quality of care requirements (Gittler, 2008; NH Regulations Plus, 2007). However, the analysis found that some regulations, such as those in Arkansas, do not explicitly address quality of care (NH Regulations Plus, 2007).

Nursing Home Staffing Requirements

Under Medicare/Medicaid certification laws and state licensing laws, nursing homes must comply not only with quality of care requirements but also with staffing requirements. Extensive literature indicates that insufficient nurse staffing levels, nursing staff without needed qualifications, and high nursing staff turnover rates contribute to the provision of inadequate care to nursing home residents. For a current comprehensive review of this literature, see Maas, Specht, Buckwalter, Gittler, and Bechen (2008a) and Collier and Harrington (2008). Similarly, there is literature indicating that staffing shortages, staff burnout, and a lack of staff training contribute to the mistreatment of nursing home residents (Lindbloom, Brandt, Hough, & Meadows, 2007; Maas et al., 2008a; U.S. Senate, Committee on Finance, 2002).

The Medicare/Medicaid statutes and regulations enunciate as a general standard that nursing homes must have "sufficient nursing staff to attain or maintain the highest practicable well-being of each resident as determined by resident assessments and plans of care" (42 C.F.R. §483.30). Under these statutory provisions and regulations, there are several specific staffing standards for nursing homes. They must provide nursing services by an RN, licensed practical nurse (LPN), or licensed vocational nurse (LVN) to residents on a 24-hour basis; designate a licensed nurse (RN, LPN, or LVN) to serve as a charge nurse on each tour of duty; use the services of an RN for 8 consecutive hours per day, 7 days per week; and designate a full-time director of nursing who is an RN and who is prohibited from serving as a charge nurse, unless the home has an average daily occupancy of 60 or fewer residents (Gittler, 2008).

These specific staffing requirements are viewed as minimal in nature for three main reasons (Harrington et al., 2000; IOM, Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Homes, 1996; IOM, Com-

TABLE 3

Federal Quality of Care Requirements

Statutes and Regulations	Requirements
42 U.S.C. §1395 (b)(4); 42 U.S.C. §1396 (b)(4); 42 C.F.R. § 483.25	*General:* Each resident shall receive and each facility shall provide necessary care and services "to attain or maintain the highest practicable physical, mental, and psychological well-being" of the resident in accordance with the resident's comprehensive assessment and plan of care.
42 C.F.R. § 483.25 (a)	*Activities of Daily Living:* Facilities must ensure that the ability of residents to engage in activities of daily living does not diminish unless unavoidable because of their clinical condition. Activities of daily living include the ability to bathe, dress and groom, transfer and ambulate, toilet, eat, and use speech, language, or other functional communication systems. If residents cannot carry out activities of daily living, they must receive the services necessary for maintenance of good nutrition, grooming, and personal and oral hygiene.
42 C.F.R. § 483.25 (b)	*Vision and Hearing:* Facilities must ensure residents receive proper treatment and assistive devices to maintain their vision and hearing. If necessary, facilities must help residents make appointments with and arrange for transportation to and from a provider of vision and hearing services.
42 C.F.R. § 483.25 (c)	*Pressure Sores*: Facilities must ensure residents admitted without pressure sores do not develop them unless it is unavoidable. Facilities must ensure residents with pressure sores receive the necessary treatment to promote healing and to prevent infections and new sores.
42 C.F.R. § 483.25 (d)	*Urinary Incontinence:* Facilities must ensure residents receive treatment to prevent urinary tract infections and to restore normal bladder function to the extent possible. Catheterization is permissible only if it is necessary because of a resident's clinical condition.
42 C.F.R. § 483.25 (e)	*Range of Motion:* Facilities must ensure residents maintain range of motion unless reductions are unavoidable because of their clinical condition. Residents with limited range of motion must receive appropriate treatment and services to increase their range of motion and/or prevent further deterioration in their range of motion.
42 C.F.R. § 483.25 (f)	*Mental and Psychosocial Functioning:* Facilities must ensure residents receive appropriate treatment and services to prevent and/or improve a mental or psychosocial adjustment difficulty.
42 C.F.R. § 483.25 (i)	*Nutrition:* Facilities must ensure residents maintain acceptable nutritional status unless this is impossible because of the resident's clinical condition. Facilities must ensure residents receive a therapeutic diet when they have a nutritional problem.
42 C.F.R. § 483.25 (j)	*Hydration:* Facilities must ensure residents receive sufficient fluids to maintain hydration and health.
42 C.F.R. § 483.25 (g)	*Nasogastric Tubes:* Facilities must ensure residents who can eat independently or with assistance are not fed by nasogastric tubes unless their use is unavoidable because of a resident's clinical condition. Residents with nasogastric tubes must receive appropriate treatment and services to prevent vomiting, dehydration, metabolic disorders, and nasal-pharyngeal ulcers, and to restore, if possible, normal eating skills.
42 C.F.R. § 483.25 (k)	*Special Needs:* Facilities must ensure residents receive proper treatment and care for injections; parenteral and enteral fluids; colostomy, ureterostomy, or ileostomy care; tracheostomy care; respiratory care; foot care; and prostheses.
42 C.F.R. § 483.25 (l)	*Unnecessary Drugs and Antipsychotic Drugs:* The facility must ensure residents do not receive unnecessary drugs, defined as a drug used in excessive dosage, for excessive duration, without adequate monitoring, without adequate indications for use, or with adverse consequences. Facilities must ensure residents are not started on antipsychotic drugs unless clinically necessary and that if a resident receives such drugs, efforts are made to discontinue their use.
42 C.F.R. § 483.25 (m)	*Medication Errors:* The facility must ensure residents are free of any significant medication errors and that the facility medication error rate is 5% or less.
42 C.F.R. § 483.25 (h)	*Accidents:* Facilities must ensure residents' environment is as free as possible of accident hazards and that residents receive supervision and assistive devices to prevent accidents.

mittee on Improving Quality in Long-Term Care, 2001; IOM, Committee on the Work Environment for Nurses and Patient Safety, 2004; Mass et al., 2008b; Zhang, Unruh, Liu, & Wan, 2006). First, these requirements do not establish minimum nursing staff-to-resident ratios or minimum nursing supervisor-to-nursing staff ratios. Second, the requirements do not reflect the case-mix of the residents. Third, the requirements do not address staffing by nursing assistants (NAs), who provide the bulk of direct personal care to residents.

Since the promulgation of the existing Medicare/Medicaid staffing requirements 2 decades ago, the requirements have been repeatedly criticized as insufficient to ensure nursing home residents receive appropriate quality of care or to protect them from mistreatment (Harrington, 2001, 2004; Harrington et al., 2000; IOM, Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Homes, 1996; IOM, Committee on Improving Quality in Long-Term Care, 2001; IOM, Committee on the Work Environment for Nurses and Patient Safety, 2004; Mueller et al., 2006; National Citizen's Coalition for Nursing Home Reform, 1995, 1998; U.S. Senate, Committee on Finance, 2003b; U.S. Senate, Special Committee on Aging, 2007f, 2007h; Wells, 2004; Zhang et al., 2006). Although there is widespread agreement that federal staffing standards for Medicare/Medicaid facilities should be raised, there is an ongoing debate about just what these standards should be. Some prominent and influential organizations have recommended, or endorsed, standards that include specific minimum staff-to-resident ratios (Harrington et al., 2000; IOM, Committee on Improving Quality in Long-Term Care, 2001; IOM, Committee on the Work Environment for Nurses and Patient Safety, 2004; National Citizen's Coalition for Nursing Home Reform, 1995, 1998).

During the period 2000-2001, the U.S. Department of Health and Human Services (USDHHS) submitted two reports to Congress describing the results of a congressionally mandated study, conducted under the auspices of the Centers for Medicare & Medicaid Services (CMS), that examined the appropriateness of establishing minimum nursing staff-to-resident ratios for nursing homes certified by Medicare and Medicaid (CMS, 2001; Health Care Financing Administration, 2000). This CMS study identified staffing level thresholds below which improvements in the quality of care and resident outcomes occurred and above which no further improvement was observed. The study found that a large proportion of facilities failed to meet these thresholds (CMS, 2001).

The study findings provided an empirical basis for new federal Medicare/Medicaid staffing level standards with minimum nursing staff-to-resident ratios (Feuerberg, 2001). Nevertheless, the Secretary of the USDHHS, on behalf of the USDHHS, took the position that the study was "insufficient for determining the appropriateness of staffing ratios" (Thompson, 2002a, 2002b, 2002c, p. 1). The USDHHS position also reflected concern that adoption of these ratios would increase the overall costs of nursing home care by increasing the costs of nursing staff, which in turn would generate pressure for increasing Medicaid reimbursement rates (Feuerberg, 2001; Harrington, 2001). It should be noted in this regard that the Medicare and Medicaid programs pay the costs of a substantial amount of nursing home care.

In response to the findings of the USDHHS study and other studies showing a strong positive relationship between nursing home quality of care and staffing, bills periodically have been introduced in Congress to amend the Social Security Act so as to establish higher minimum nursing staffing standards for nursing homes certified by Medicare and Medicaid (Library of Congress, 2003a, 2003b, 2005). However, to date, attempts to enact legislation establishing more stringent federal standards have been unsuccessful.

The staffing requirements to which nursing homes must conform are not confined to those in Medicare/Medicaid certification laws. Nursing homes also must meet staffing requirements in state licensing laws. These laws usually reiterate some form of the general federal staffing standard that calls for nursing homes to employ staff sufficient to meet the needs of residents, as set forth in residents' assessment and care plans (Gittler, 2008).

Specific federal staffing requirements, which it has been pointed out are minimal in nature, are exceeded by the staffing requirements of most state licensing statutes and regulations (Gittler, 2008; NH Regulations Plus, 2007). In Arkansas, California, Iowa, Oregon, Pennsylvania, and 32 other states, state licensing statutes and regulations, unlike the Medicare/Medicaid certification statutes and regulations, mandate minimum staff-to-resident ratios (Gittler, 2008; NH Regulations Plus, 2007). However, considerable variation exists among states in the actual ratios required (Gittler, 2008).

Some state laws also link staffing level requirements to kinds of nursing staff (RNs, LPN/LVNs, and NAs) and specify the ratio of staff to residents by kind of staff (Gittler, 2008). Here again, considerable variation exists among states in the kinds of nursing staff required (Git-

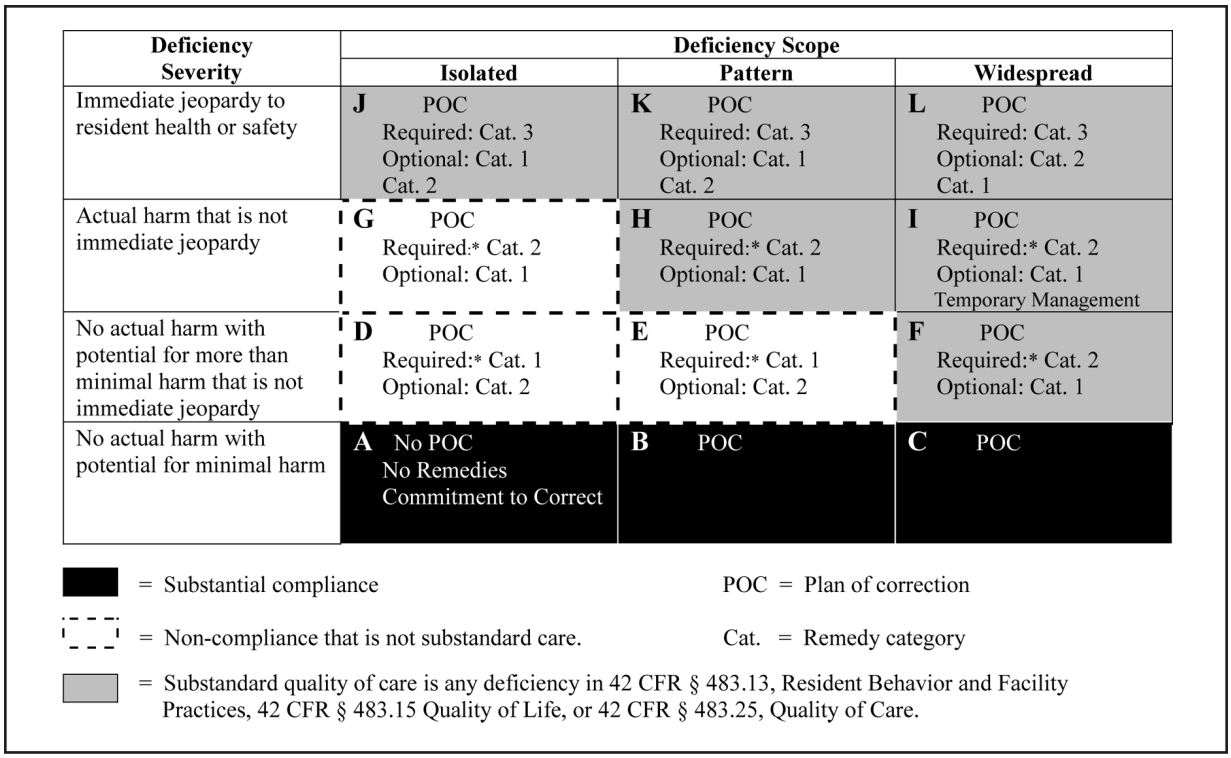

Figure 1. Scope and severity grid and remedy categories used to rank nursing home deficiencies.
* These remedy categories are required only when a decision is made to impose alternative remedies in lieu of or in addition to termination.
Adapted from Centers for Medicare & Medicaid Services (2004).

tler, 2008). During the past decade, a few states, most notably Florida and California, have significantly raised their minimum nursing home staffing standards (Harrington & O'Meara, 2006; Hyer, 2007; NH Regulations Plus, 2007; Polivka, Salmon, Hyer, Johnson, & Hedgecock, 2003).

Monitoring of Nursing Home Compliance

The Medicare/Medicaid statute and regulations set forth a detailed process, known as the survey process, to monitor whether nursing homes are in compliance with quality of care, staffing, and other substantive requirements for Medicare/Medicaid participation. The federal and state governments share responsibility for the survey process (Gittler, 2008). CMS, which is part of the USDHHS, issues regulations and interpretive guidelines and protocols pertaining to the survey process and contracts with state agencies, known as state survey agencies, to implement the survey process.

State survey agencies must conduct an unannounced standard survey, or inspection, of every facility participating in the Medicaid and Medicare programs at least once every 15 months, and the average statewide time interval for these surveys must not exceed 12 months. In conducting these surveys, the state surveyors must follow CMS survey protocols and interpretative guidelines, which are detailed, complex, and prescriptive (Gittler, 2008). Survey agencies also must conduct investigations of specific complaints about inadequate nursing home care by residents, their relatives, and others (Gittler, 2008).

In the course of surveys or complaint investigations, nursing homes may be cited for a deficiency, which is defined as a failure to meet a Medicaid or Medicare participation requirement (Gittler, 2008). When state surveyors identify deficiencies, they must determine their seriousness. CMS provides guidance to state survey teams for determining the seriousness of identified deficiencies in accordance with a scope and severity scale (Gittler, 2008). The scope scale ranks a deficiency on the basis of the number of residents affected (i.e., whether it is isolated, a pattern, or widespread), and the severity scale ranks a deficiency on the basis of the degree of resident harm (i.e., whether it creates a risk of minimal harm, creates a risk of more than minimal harm, causes actual harm, or poses immediate jeopardy to the health or safety of a facility resident). This scale groups deficiencies into 12 categories from A to L,

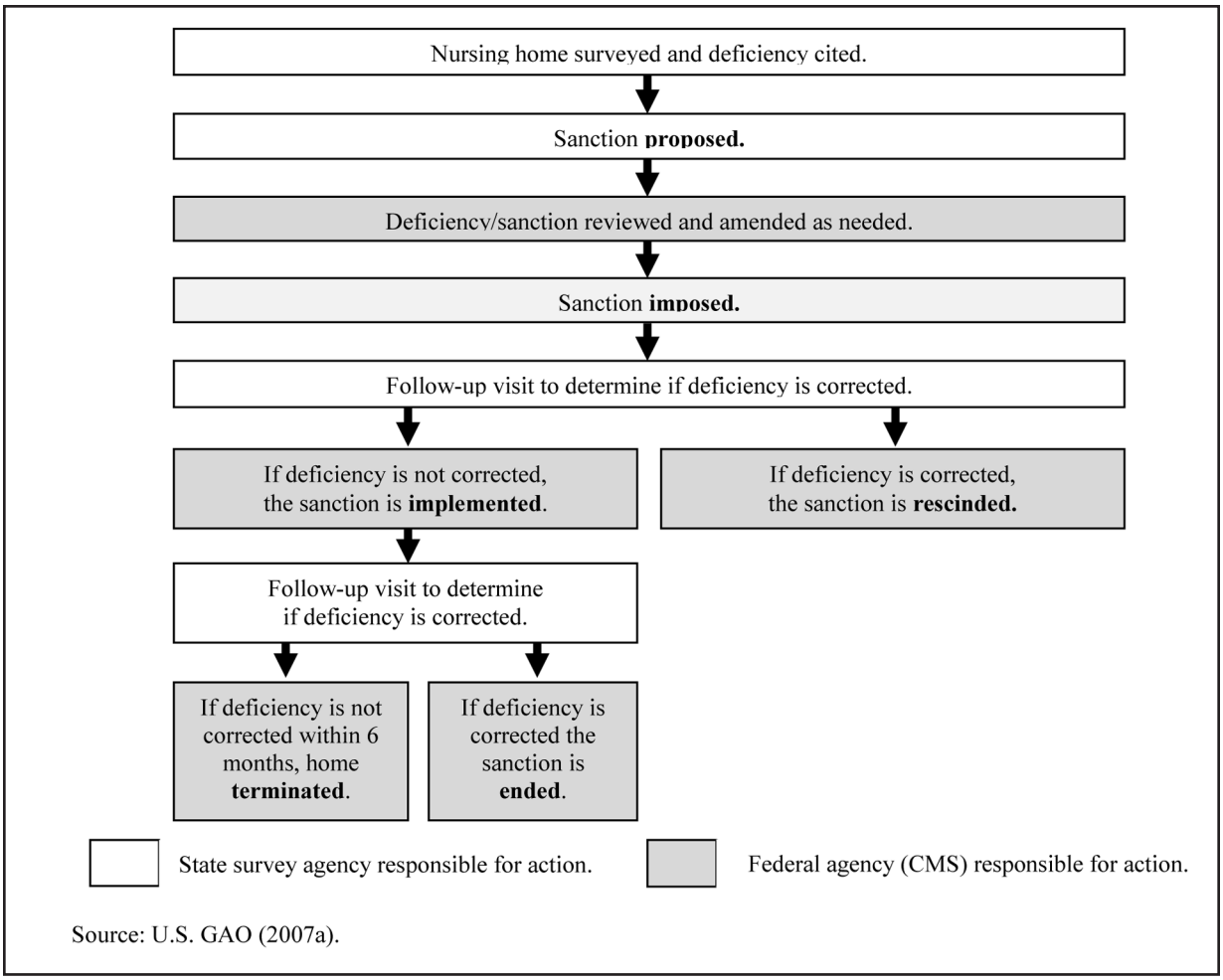

Figure 2. Federal and state responsibilities in the nursing home compliance enforcement process.

with A-level deficiencies being the least serious and L-level deficiencies being the most serious. **Figure 1** provides the CMS grid of scope and severity rankings.

A determination of substantial compliance allows the state or CMS to approve a nursing home's initial certification or renewal of certification (Gittler, 2008). As indicated in **Figure 1,** nursing homes are deemed to be in substantial compliance if the highest deficiency for which they are cited is a C-level deficiency, and they are deemed not to be in substantial compliance when the highest deficiency for which they are cited is a D-level deficiency or higher.

States may establish their own process for the licensing of nursing homes and the enforcement of licensing requirements under their independent licensure authority. State survey agencies also serve as state licensing agencies, and states typically follow the survey process, or some variant thereof, in licensing nursing homes (Gittler, 2008).

Process for Enforcing Nursing Home Compliance

The Medicare and Medicaid provisions of the Social Security Act and their implementing regulations specify the process for enforcement of nursing home compliance with Medicare/Medicaid participation requirements. This process is intended to ensure prompt correction of deficiencies to protect residents from actual or potential harm and to deter future noncompliance (Gittler, 2008). The enforcement process, like the survey process, is a joint federal and state responsibility (Gittler, 2008). **Figure 2** provides a flow chart illustrating the respective federal and state responsibilities in the enforcement process.

If nursing homes are not in substantial compliance with Medicare/Medicaid participation requirements, statutory and regulatory provisions authorize several kinds of federal remedies, ranging from a directed plan of correction to termination of participation in the Medicare/Medicaid programs (Gittler, 2008). The most frequently used rem-

TABLE 4

Remedy Categories Used When Nursing Homes Are Cited for Deficiencies by State Survey Agencies

Category 1	Category 2	Category 3
• Directed plan of correction	• Denial of payment for new admissions	• Temporary management
• State monitor	• Denial of payment for all residents	• Termination
• Directed inservice training	• Civil monetary penalties ($50 to $3,000 per day or $1,000 to $10,000 per instance)	• Optional: Civil monetary penalties ($3,050 to $10,000 per day or $1,000 to $10,000 per instance)

Adapted from Centers for Medicare & Medicaid Services (2004).

edy is the civil monetary penalty (CMP), an intermediate sanction, consisting of a fine for each day or instance of noncompliance (U.S. GAO, 2007b).

When nursing homes are cited for deficiencies by state survey agencies, they are usually required, at a minimum, to develop and implement a plan of correction (Gittler, 2008). In addition to a plan of correction, other remedies must or may be imposed. These remedies are grouped in three categories in accordance with the severity of the remedy (Gittler, 2008). **Table 4** contains the remedy categories. After the seriousness of deficiencies is determined, the enforcement authority selects one or more remedies from the applicable remedy category (Gittler, 2008). The more serious the deficiency, as measured by the scope and severity scale, the more severe the remedies in the applicable remedy category (**Figure 1**).

Nursing homes cited for deficiencies normally have a grace period during which they can avoid the imposition of sanctions if they correct the deficiencies (Gittler, 2008). As a result of criticism that undue delays were occurring between the findings of serious deficiencies involving harm to residents and the imposition of sanctions, CMS instituted the immediate sanctions policy, under which state survey agencies must refer nursing homes for immediate sanctions when they are cited for G-level deficiencies or higher on successive surveys (Fogge, 2007; Gittler, 2008; U.S. GAO, 2007b).

States have the authority to establish their own remedies for violations of state licensing laws, and these laws do, in fact, provide remedies for violations of quality of care, staffing, and other licensing requirements. Under state licensing laws, including those of Arkansas, California, Iowa, Oregon, and Pennsylvania, the primary remedies for such violations are CMPs (Gittler, 2008). In theory, substandard care in a nursing home could lead to the imposition of both federal and state remedies; in practice, most states impose either one or the other (Fogge, 2007). Although some states favor use of federal remedies, others prefer use of state remedies (Fogge, 2007; Hawes, 2002a; U.S. GAO 2007b).

Weaknesses in Governmental Monitoring and Enforcement Efforts

Persistent weaknesses in federal and state monitoring of the compliance of nursing homes with quality of care, staffing, and other requirements for Medicare/Medicaid certification and state licensing have been well documented. The U.S. Government Accountability Office (GAO) (formerly the U.S. General Accounting Office), the USDHHS Office of Inspector General (OIG), and congressional committees have played a leading role in the documentation of such weaknesses at the federal level (USDHHS OIG, 1993, 1999a, 1999b, 1999c, 2003, 2006a; U.S. GAO, 1998, 1999a, 1999c, 2000, 2002a, 2002b, 2003, 2004, 2005, 2007a, 2008; U.S. Senate, Committee on Finance, 2003a; U.S. Senate, Special Committee on Aging, 1998, 1999a, 1999b, 2000, 2007f, 2007g). In addition, state audit agencies and legislative bodies have played a leading role in the documentation of such weaknesses at the state level (California Legislative Analyst's Office, 2006; California State Auditor, Bureau of State Audits, 2007; Minnesota Management Analysis Division, 2004; Minnesota Office of the Legislative Auditor, 2005). Public policy think tanks and researchers have also identified problems with the monitoring of nursing home compliance (Harrington & Carrillo, 1999; IOM, Committee on Improving Quality in Long-Term Care, 2001; Johnson & Kramer, 1998; Lee, Gajewski, & Thompson, 2006; Louwe, Parry, & Kramer, 2007; Miller & Mor, 2008; Walshe & Harrington, 2002; Wright, 2001, 2005). Furthermore, both consumer advocacy organizations and the nursing home industry have been critical of compliance monitoring, although for somewhat different reasons (American

Association of Homes and Services for the Aging, 2007, 2008; American Medical Directors Association, 2002; California Advocates for Nursing Home Reform, 2006; Levenson & Crecelius, 2002; Rudder, Mollot, & Sobel, 2005; Rudder & Shineman, 2006).

Weaknesses in the monitoring of nursing home compliance have raised several specific concerns about the survey process that revolve primarily around its consistency and accuracy. A number of studies and reports have lent support to these concerns (Abt Associates, 1996; American Association of Homes and Services for the Aging, 2008; Harrington & Carrillo, 1999; Harrington, Mullen, & Carrillo, 2004; IOM, Committee on Improving Quality in Long-Term Care, 2001; Johnson & Kramer, 1998; Lee et al., 2006; Louwe et al., 2007; Miller & Mor, 2008; USDHHS OIG, 2003; U.S. GAO, 1998, 2003, 2004, 2005, 2007a, 2007b, 2008). These studies and reports have shown considerable variation in the way in which survey teams conduct surveys between and within some states and significant understatement of the existence and seriousness of deficiencies by state surveyors in some states.

Just as weaknesses in the monitoring of compliance with Medicare/Medicaid and state licensing requirements have been well documented, so too have weaknesses in the enforcement of these requirements (American Association of Homes and Services for the Aging, 2008; Edelman, 1998; Harrington & Carrillo, 1999; Harrington et al., 2004; Hawes, 2002a; IOM, Committee on Improving Quality in Long-Term Care, 2001; Miller & Mor, 2008; Tsoukalas et al., 2006; USDHHS OIG, 2005a, 2005b, 2005c, 2006b; U.S. GAO, 1999b, 1999d, 2000, 2007b; U.S. Senate, Special Committee on Aging, 2007f, 2007g, 2007i, 2007j; Wood 2002; Wright, 2001, 2005). Studies and reports have disclosed significant interstate variation in the level of enforcement activities. Studies and reports also have disclosed that the use of CMPs as a remedy for noncompliance differed considerably between states, that a significant proportion of CMPs imposed nationwide were not collected or were collected after their due date, and that CMPs often were imposed at the lower end of the permissible dollar range. Particularly troubling are studies detailing persistent problems in the enforcement of quality of care requirements related to nursing homes with a history of repeatedly harming residents that cycle in and out of compliance.

The aforementioned monitoring and enforcement weaknesses have been attributed to a variety of factors. One set of such factors relates to the staffing of state agencies that are responsible for Medicare/Medicaid certification and licensing. For example, the U.S. GAO (2008) recently reported that state survey teams nationwide were missing quality of care deficiencies because surveyors lacked investigative skills and the ability to integrate and analyze information collected during surveys. It likewise has been reported that inadequate staffing levels, high staff turnovers, and insufficiently trained and experienced staff may negatively affect the performance of survey and licensing agencies (American Association of Homes and Services for the Aging, 2008; Louwe et al., 2007; U.S. GAO, 2003, 2005, 2007a; USDHHS OIG, 2003; Wright, 2005).

Factors related to the funding made available to state survey and licensing agencies may also contribute to monitoring and enforcement weaknesses. Thus, funding constraints may make it difficult for an agency to establish and maintain appropriate staffing levels and to recruit and retain qualified staff to carry out monitoring and enforcement activities (American Association of Homes and Services for the Aging, 2008; Louwe et al., 2007; U.S. GAO, 2005, 2007b; Walshe & Harrington, 2002).

Still other factors have been cited as contributing to monitoring and enforcement weaknesses. They include shortcomings in some aspects of CMS survey methodology and a lack of clarity with respect to some CMS survey guidelines and protocols; the predictability of the timing of "unannounced" standard surveys, which enables facilities to prepare for surveys and conceal problems; inadequate quality assurance processes to detect understatement in the scope and severity of deficiencies at the state level, and inadequate CMS oversight of the state survey process (Louwe et al., 2007; U.S. GAO, 2003, 2005, 2007a, 2007b, 2008; USDHHS OIG, 2003; Wright, 2005).

Relates to principal agent theory.

How predictable are the survey?

Although the influence of factors of a political nature on monitoring and enforcement activities have received little attention from researchers, it has been suggested that the political environment adversely impacts these activities. More specifically, there is evidence that some state survey and licensing agencies have been subjected to political pressure, generated by nursing homes, to overlook or downgrade deficiencies, and there is some evidence that the nursing home industry in some states has lobbied against legislative attempts to strength monitoring and enforcement activities (Consumer Reports, 2006; Grassley, 2004; Meitrodt, 2005; O'Connor & Schneider, 2002).

Potential political pressures is another weakeness

ELDER ABUSE LAWS

Laws prohibiting mistreatment of nursing home residents are another important component of the legal frame-

work within which nursing homes must operate. These laws are commonly referred to as elder abuse laws. The National Center on Elder Abuse (NCEA) generally defines elder abuse as "any knowing, intentional, or negligent act by a caretaker or other person that causes harm or serious risk of harm to a vulnerable adult" (2007a, p. 1). According to the NCEA (2007a), the main kinds of elder abuse are physical abuse, sexual abuse, emotional or psychological abuse, neglect, abandonment, and financial or material exploitation. A variety of legal definitions of the term elder abuse appear in numerous state statutes and a few federal statutes (American Bar Association Commission on Law and Aging, 2005a, 2005b; Bonnie & Wallace, 2002; Gittler, 2008; NCEA, 2007b, 2007c).

The true prevalence and incidence of elder abuse is unknown. However, available evidence dictates the conclusion that elder abuse in nursing homes and other institutional and domestic settings is a serious, widespread, and largely hidden problem (Bonnie & Wallace, 2002; Hawes, 2002b; Lindbloom et al., 2007; Loue, 2001; NCEA, 2005; Teaster et al., 2006; U.S. House of Representatives, Committee on Government Reform, Special Investigations Division, Minority Staff, 2001; U.S. House of Representatives, Select Committee on Aging, Subcommittee on Human Services, 1991; U.S. Senate, Committee on Finance, 2002, 2003b; U.S. Senate, Special Committee on Aging, 2007a).

It is well established that states can exercise their inherent police power to protect vulnerable populations, such as elder abuse victims. One approach to elder abuse on the part of states is the provision of state protective services (Adult Protective Services, or APS) to older adults who have been or are at risk of being abused. The National Association of Adult Protective Services defines APS as "services provided to older people and people with disabilities who are in danger of being mistreated or neglected, are unable to protect themselves, and have no one to protect them" (Teaster et al., 2006, p. 9). APS laws have been enacted in all 50 states (American Bar Association Commission on Law and Aging, 2005a, 2006; Gittler, 2008).

A key element of the APS approach to elder abuse is to increase the identification of older adults who are in need of protection from abuse and who might otherwise not come to the attention of the authorities through reporting statutes. These statutes require certain classes of individuals, called mandatory reporters, to report known or suspected cases of elder abuse to the authorities, and they authorize other individuals, called voluntary reporters, to make reports. The Arkansas, California, Iowa, Oregon, and Pennsylvania reporting laws are typical of such laws in that they designate physicians, nurses, other health professionals, and specified nursing home personnel as mandatory reporters (American Bar Association Commission on Law and Aging, 2005a, 2005b; Gittler, 2008).

Disagreement exists about the effectiveness of mandatory reporting statutes as a case-finding method (Daly, Jogerst, Brinig, & Dawson, 2003; Glick, 2005; Rodriguez, Wallace, Woolf, & Mangione, 2006; Rosenblatt, Cho, & Durance, 1996; Silva, 1992; U.S. GAO, 1991; Velick, 1995). Underlying these statutes are the assumptions that older adults, especially those with cognitive impairments and those who rely on their abusers for care, may be unable or unwilling to reveal their situation and that individuals designated as mandatory reporters have the necessary expertise to identify actual or potential victims of abuse (Fulmer, Guadagno, Bitondo Dyer, & Connolly, 2004). However, if an older adult does not report being abused, it can be difficult to identify abuse, in part because its signs and symptoms may be mistaken for illnesses or changes normally associated with aging.

Progress has been made in developing elder abuse screening and assessment instruments and forensic markers of abuse, but more work must be done in this area (Anonymous, 2002; Dyer, Connolly, & McFeeley, 2002; Fulmer et al., 2004; Hunsaker & Hunsaker, 2005; McNamee & Murphy, 2006). In addition, mandatory reporters who know or suspect elder abuse may not necessarily file a report. Several studies have indicated significant underreporting of elder abuse and noncompliance with mandatory reporting requirements (Clark-Daniels, Daniels, & Baumhover, 1990; Daly & Jogerst, 2005; Jogerst, Daly, & Ingram, 2001; Peduzzi, Watzlaf, Rohrer, & Rubenstein, 1997; Rodriguez et al., 2006; Rosenblatt et al., 1996).

State reporting statutes vary as to what agency receives and investigates reports, how reports are investigated, and what occurs when an investigation is completed (American Bar Association Commission on Law and Aging, 2005a; Gittler, 2008). In general, when a report of abuse in a nursing home is substantiated, the state agency responsible for licensure and certification of the nursing home will determine what action to take against the nursing home; if the employee who committed the abuse is a licensed health professional, the relevant state professional licensure agency will determine what action to take against the employee (Gittler, 2008).

Another approach that states have taken related to elder abuse is to criminalize it. A number of states, such as Arkansas, California, Iowa, Pennsylvania, and Oregon, have enacted statutes making abuse of older adults a specific crime, and some of these statutes explicitly state that

elder abuse in a nursing home or other institutional setting is a criminal offense (Buchwalter, 2003/2007; Gittler, 2008; Loue, 2001). Other states have statutes that authorize enhanced penalties for the commission of a criminal offense against an elderly victim (Bremer, 1999/2007; Gittler, 2008). Still other states have sentencing guidelines under which the fact that the victim of a crime is elderly may be an aggravating factor for the purpose of sentencing the offender (Ramares, 1989/2007). Even in the absence of a specific elder abuse criminal statute, conduct constituting elder abuse may be prosecuted under generic state criminal laws applicable to both elderly and non-elderly victims (American Bar Association Commission on Law and Aging, 2005b; American Prosecutors Research Institute, 2003a; Davidson, 2004; Moskowitz, 2003).

It is the responsibility of local law enforcement officers and prosecutors to enforce elder abuse criminal laws, and state attorney generals sometimes also play a role in enforcement of these laws (Gittler, 2008). Law enforcement and prosecution agencies historically treated elder abuse as a civil matter, rather than as a crime to be investigated and prosecuted like other crimes against individuals (Blakely & Dolon, 2000; Heisler, 2000; Heisler & Stiegel, 2004). As awareness of the problem of elder abuse has increased, it has begun to receive more attention from law enforcement and prosecution agencies (American Prosecutors Research Institute, 2003b; Greenwood, 1999; Heisler, 2000; Heisler & Stiegel, 2004; Moskowitz, 2003; National District Attorneys Association, 2003; State of California Department of Justice, Bureau of Medi-Cal Fraud and Elder Abuse, 2004; U.S. Senate, Special Committee on Aging, 2007d).

When law enforcement and prosecution agencies do decide to pursue elder abuse cases, they frequently encounter difficulties (American Prosecutors Research Institute, 2003a, 2003b; Davidson, 2004; Heisler, 2000; U.S. GAO, 2002b; Zahner, 1999). A major impediment to the effective investigation and prosecution of alleged abuse cases of nursing home residents is a failure to report these cases altogether or to report them promptly to law enforcement authorities, thereby compromising the availability and integrity of evidence. Effective investigation and prosecution of these cases may also be hindered, or precluded, by the diminished mental and physical capacities of many elder abuse victims and their reluctance to cooperate, together with the lack of other witnesses to incidents of abuse.

Although state elder abuse laws traditionally have been the source of legal protections for nursing home residents who are actual or potential victims of abuse, the Medicare/ Medicaid statutes and regulations also attempt to protect nursing home residents from abuse. Nursing homes certified by Medicare and Medicaid must develop policies and procedures to prevent elder abuse, and state survey agencies must put into place processes for the receipt, timely review, and investigation of allegations of resident abuse (Gittler, 2008). In addition, state Medicaid Fraud Control Units (MFCUs) are charged with investigating and prosecuting not only cases of fraud by Medicaid providers but also cases of abuse of Medicaid recipients in nursing homes and other settings (USDHHS OIG, 2006c).

HEALTH CARE FRAUD AND ABUSE LAWS

Health care fraud and abuse laws supplement and reinforce Medicare/Medicaid certification laws, state licensing laws, and elder abuse laws. Broadly defined, health care fraud is an intentional deception or misrepresentation leading to unauthorized reimbursement for health services, and health care abuse is billing for services that are not medically necessary, that do not reflect professional standards for health care, or that result in unnecessary costs (Gittler, 2008).

The existing federal statutory scheme, which can be used to combat Medicare and Medicaid fraud and abuse by nursing homes, consists of general fraud statutes, health care-specific fraud statutes, and Medicare and Medicaid-specific fraud statutes (Baumann, 2002; Loucks & Lam, 2002; McGuire & Schneider, 2007). States also have fraud and abuse statutes that are applicable to nursing homes (Baumann, 2002; Loucks & Lam, 2002).

The Civil False Claims Act (FCA), a general federal fraud statute, has been one of the primary governmental weapons against Medicare and Medicaid fraud by nursing homes (Gittler, 2008). FCA liability requires proof that a party knowingly presented a false or fraudulent claim to the federal government. FCA violators are subject to heavy civil sanctions—fines of $5,500 to $11,000 per false claim plus treble damages. A unique feature of the FCA is that it permits private citizens, who the FCA refers to as qui tam relators and who are more familiarly known as whistleblowers, to bring suit on behalf of the United States and to retain 15% to 25% of any damages recovered. Consequently, if nursing home employees or other individuals know a nursing home has defrauded the Medicare or Medicaid programs, they have a financial incentive to file a FCA suit against the nursing home.

The FCA has customarily been used in cases in which providers have billed for services that were not actually provided and those in which providers have manipulated the

coding of claims to maximize reimbursement. In the 1996 Geri-Med case, the federal government filed a complaint against a nursing home and its management company alleging for the first time that billing Medicare for substandard care of residents constituted a false claim under the FCA (Hoffman, 1997). This case marked the beginning of FCA "failure of care" cases involving nursing homes (Connolly, 2001).

Although some courts have rejected the validity of legal theories developed to support FCA failure of care cases, others courts have been more receptive to these theories (Blackwood & Daniels, 2003; Connolly, 2001; Davidson, 2004; Hoffman, 1997; Mustokoff, 2007; Mustokoff, Werner, & Yecies, 1997). But failure of care cases that are actually tried before a court are just the proverbial tip of the iceberg. The government has brought many actions alleging failure of care that were never litigated because of settlement agreements (Connolly, 2001; Hoffman, 1997; U.S. Senate, Special Committee on Aging, 2007b, 2007c).

Government failure of care cases have resulted in the imposition of multiple and substantial civil and administrative sanctions on nursing homes (Connolly, 2001; U.S. Senate, Special Committee on Aging, 2007b, 2007c). In failure of care case settlements, the government also typically requires nursing homes to correct quality of care problems in a specified manner and sometimes requires them to employ government-selected independent monitors, who have unrestricted access to facilities, staff, residents, and records, and who make recommendations to improve the quality of care (Connolly, 2001; Hoffman, 1997; U.S. Senate, Special Committee on Aging, 2007b, 2007c).

FCA failure of care cases may be the harbinger of things to come in terms of a nexus between government efforts to both control and prevent health care fraud and abuse and to improve health care quality, which were stimulated, at least to some extent, by an intensive national health care quality initiative launched by the IOM in the 1990s (IOM, Committee on Quality of Health Care in America, 2000, 2001). Some experts predict that provision of care by nursing homes and other providers that do not meet evidence-based quality of care standards increasingly will become the focal point of government enforcement of health care fraud and abuse laws (Gosfield, 2003, 2007; Sheehan, Wagonhurst, & Smithline, 2007).

LONG-TERM CARE OMBUDSMAN LAWS

Long-term care ombudsman laws, like health care fraud and abuse laws, supplement and reinforce Medicare/Medicaid certification laws, state licensing laws, and elder abuse laws. The Older Americans Act makes federal financial assistance available to states for long-term care ombudsman programs (LTCOPs) (Gittler, 2008). Under the Older Americans Act, state LTCOPs have an extremely broad general mandate to promote the health, safety, well-being, and rights of residents of nursing homes and other long-term care facilities (Gittler, 2008).

The Act more specifically provides that the state LTCOPs are to act as advocates for individual nursing home residents. One of their chief responsibilities related to individual advocacy is the investigation and resolution of complaints, including complaints pertaining to quality of care brought by, or on behalf of, nursing home residents (Gittler, 2008). The most common complaints are related to inadequate care due to insufficient staff (U.S. Administration on Aging, 2007a). Although LTCOPs can investigate complaints against nursing homes, they cannot compel nursing homes to take needed corrective actions, and in the event they discover a failure on the part of nursing homes to comply with quality of care requirements or to protect residents from abuse, they must rely on other agencies and authorities for any needed enforcement actions. Therefore, it is important for LTCOPs to have links and good working relationships with these agencies and authorities (Estes, 2006; Estes, Zulman, Goldberg, & Ogawa, 2001, 2004).

The Older Americans Act also gives state LTCOPs other responsibilities. They are charged with conducting systemic advocacy to improve long-term care, promoting the development of citizens' organizations to participate in program activities, assisting in the development of family and resident councils in nursing homes, and educating consumers, providers, and the public about long-term care (Gittler, 2008).

All 50 states have enacted enabling statutes establishing LTCOPs (Gittler, 2008; National Association of State Units on Aging, 2002). Most of these state-enabling statutes and their implementing regulations track the provisions of the Older Americans Act and usually state that the LTCOPs shall engage in individual advocacy, systemic advocacy, and the development of citizens' organizations, family and resident councils, and educational activities.

In some states, statutes and regulations permit or require LTCOPs to assume additional duties. For example, in some states, long-term care ombudsmen are authorized to serve as investigators of alleged violations of elder abuse laws in long-term care facilities (Gittler, 2008; National Association of State Units on Aging, 2002).

Although the Older Americans Act delineates the specific functions of LTCOPs, states have a great deal of discretion in determining their organization and structure. State-enabling statutes designate a variety of organizational entities to administer these programs at the state level. Many programs are located within a state unit on aging, which may be an independent agency or part of a larger agency; some programs are located within another state agency; and a few programs are located outside of the state government agency structure and are operated by entities such as legal service organizations and nonprofit organizations (Gittler, 2008). The many programs located within the state government bureaucracy may lack the organizational autonomy for systemic advocacy and individual advocacy (Estes et al., 2001, 2004).

The Older Americans Act also gives considerable discretion to states in the staffing of their LTCOPs. The LTCOPs have full-time paid staff, but most programs rely heavily on volunteers to staff the regional and local offices that provide ombudsman services (Gittler, 2008; U.S. Administration on Aging, 2007b). The number of full-time paid ombudsmen varies widely among states. The generally accepted minimum staffing standard for LTCOPs of one full-time paid ombudsman per 2,000 long-term care beds is one that some programs do not meet (IOM, Committee to Evaluate the State Long-Term Care Ombudsman Programs, Division of Health Care Services, 1995; U.S. Administration on Aging, 2007b). An inadequate number of full-time paid staff and trained volunteers due to insufficient federal and state funding has hampered the ability of state and local LTCOPs to fulfill their mandates under the Older Americans Act and state-enabling statutes and implement regulations (Estes, 2006; Estes et al., 2001, 2004; Gittler, 2008; IOM, Committee to Evaluate the State Long-Term Care Ombudsman Programs, Division of Health Care Services, 1995).

COMPLEXITY OF THE STATUTORY AND REGULATORY SCHEME AND FRAGMENTATION OF IMPLEMENTATION EFFORTS

Multiple separate but overlapping nursing home statutes and regulations pertinent to the care and treatment of nursing home residents have created a statutory and regulatory scheme that is highly complex. Moreover, multiple governmental entities at the federal, state, and local levels are involved with the implementation of these statutes and regulations. **Table 5** lists the pertinent governmental entities with implementation responsibilities in Arkansas, California, Iowa, Pennsylvania, and Oregon. The involvement of so many different entities produces fragmentation of governmental efforts to ensure nursing home residents receive appropriate quality of care and are protected from mistreatment, and such fragmentation can in turn produce gaps in and duplication of such efforts.

There are several consequences of the complexity of the statutory and regulatory scheme and the fragmentation of implementation efforts. One consequence is that nursing homes must cope with what are, or what seem to be, unclear, confusing, and inconsistent requirements. Another consequence is that when nursing home residents receive substandard care or mistreatment, they, their families, and their friends must negotiate a maze of government agencies and authorities to obtain assistance. It is important to minimize, to the extent possible, these problems by creating processes for effective communication between the governmental entities that implement nursing home statutes and regulations and by developing mechanisms for coordination and integration of their activities.

CONCLUSION

The 20th anniversary of the enactment of the Nursing Home Reform Act of 1987 provided an opportunity to evaluate the effectiveness of governmental efforts to improve the quality of care for nursing home residents and to protect them from mistreatment (U.S. Senate, Special Committee on Aging, 2007a, 2007b, 2007c, 2007d, 2007e, 2007f, 2007g, 2007h, 2007i, 2007j; Weiner et al., 2007). The Nursing Home Reform Act as well as other laws are widely credited with having improved the care and treatment of nursing home residents; yet, serious problems related to the provision of inadequate care to residents and mistreatment of residents persist. In short, much has been accomplished, but many challenges remain.

Among the many individuals who have a direct stake in more effective regulation of nursing homes are public policy makers, nursing home regulators, nursing home owners and operators, and nursing home staff. The most important stakeholders, however, are nursing home residents themselves—many of whom are not in a position to act as their own advocates—and their families and friends. Ultimately, members of the general public are stakeholders inasmuch as there is, or at least should be, a broader societal obligation to ensure nursing home residents receive appropriate care and are able to live their lives in safety and with dignity.

TABLE 5

Nursing Home Statutes and Regulations: Entities Responsible for Implementation

State	Federal Medicare/ Medicaid Certification Laws		State Licensing Laws	Elder Abuse Laws			Health Care Fraud and Abuse Laws				LTC Ombudsman Laws		
	Federal Agency	State Survey Agency	State Licensing Agency	State Adult Protective Service Laws / Elder Abuse Reports & Investigations	State Criminal Laws	Federal Medicare/ Medicaid Certification Laws & State Licensing Laws	Federal False Claims Act & Federal Statutes		State Statutes		Federal Older Americans Act	State-Enabling Statutes	
				State Agencies	State & Local Agencies		Federal Agencies	State Agencies	State Agencies	Local Agencies	Federal Agencies	State Agencies	Local Agencies
Arkansas	CMS, CMS regional offices	Dept. of Human Services, Div. of Medical Services, Office of LTC	Dept. of Human Services, Div. of Medical Services, Office of LTC	• Dept. of Human Services, Office of LTC • Local law enforcement	• Attorney General's office • State medical examiner/county coroners • Local law enforcement • Local prosecuting agencies (prosecuting attorneys)	• Dept. of Human Services, Div. of Medical Services, Office of LTC • Attorney General's office, MFCU	• OIG • DOJ/U.S. Attorney's offices • Federal investigative agencies (e.g., FBI, U.S. Postal Service)	Attorney General's office, MFCU	Attorney General's office	• Local law enforcement • Local prosecution agencies (county attorneys)	AoA	Dept. of Human Services, Div. of Aging & Adult Services, Office of State LTC Ombudsman	Office designates sub-state units, primarily area agencies on aging
California	CMS, CMS regional offices	Dept. of Public Health, Licensing & Certification Div.	Dept. of Public Health, Licensing & Certification Div.	• Local LTCOPs • Local law enforcement • Attorney General's office, MFCU See also LTC ombudsman laws	• Attorney General's office • State & local medical examiners/coroners • Local law enforcement • Local prosecuting agencies (district attorneys)	• Dept. of Public Health, Licensing & Certification Div. • Attorney General's office, Bureau of Medi-Cal Fraud & Elder Abuse	• OIG • DOJ/U.S. Attorney's offices • Federal investigative agencies	Attorney General's office, MFCU	Attorney General's office	• Local law enforcement • Local prosecuting agencies (district attorneys)	AoA	Office of State LTC Ombudsman, Dept. of Aging	Dept. of Aging allocates funds to local LTCOPs
Iowa	CMS, CMS regional offices	Dept. of Inspections & Appeals, Div. of Health Facilities	Dept. of Inspections & Appeals, Div. of Health Facilities	• Dept. of Inspections & Appeals See also LTC ombudsman laws	• Local law enforcement • State/county medical examiners • Local prosecuting agencies (county attorneys)	Dept. of Inspections & Appeals, Div. of Health Facilities and Investigations Div., MFCU	• OIG • DOJ/U.S. Attorney's offices • Federal investigative agencies	Dept. of Inspections & Appeals, MFCU	Attorney General's office	• Local law enforcement • Local prosecuting agencies (county attorneys)	AoA	Resident advocates, Dept. of Elder Affairs	Resident advocate committees are appointed for each LTC facility

TABLE 5 (CONTINUED)

Nursing Home Statutes and Regulations: Entities Responsible for Implementation

State	Federal Medicare/ Medicaid Certification Laws		State Licensing Laws	Elder Abuse Laws			Health Care Fraud and Abuse Laws				LTC Ombudsman Laws		
	Federal Agency	State Survey Agency	State Licensing Agency	State Adult Protective Service Laws / Elder Abuse Reports & Investigations	State Criminal Laws	Federal Medicare/ Medicaid Certification Laws & State Licensing Laws	Federal False Claims Act & Federal Statutes		State Statutes		Federal Older Americans Act	State-Enabling Statutes	
				State Agencies	State & Local Agencies		Federal Agencies	State Agencies	State Agencies	Local Agencies	Federal Agencies	State Agencies	Local Agencies
Oregon	CMS, CMS regional offices	Dept. of Human Services, Seniors & People with Disabilities, Office of Licensing & Certification	Dept. of Human Services, Seniors & People with Disabilities, Office of Licensing & Certification	• Area agencies on aging • Dept. of Human Services • Local law enforcement See also LTC ombudsman laws	• Attorney General's office • Local law enforcement • State/county medical examiners • Local prosecuting agencies (district attorneys)	• Dept. of Human Services, Seniors & People with Disabilities • Attorney General's office, MFCU	• OIG • DOJ/U.S. Attorney's offices • Federal investigative agencies	Attorney General's office, MFCU	Attorney General's office	• Local law enforcement • Local prosecuting agencies (district attorneys)	AoA	Office of State LTC Ombudsman (free-standing, independent entity)	Office appoints designees to serve as local representative
Pennsylvania	CMS, CMS regional offices	Dept. of Health, Bureau of Facility Licensure & Certification	Dept. of Health, Bureau of Facility Licensure & Certification	• Area agencies on aging • Local law enforcement See also LTC ombudsman laws	• Attorney General's office, Elder Abuse Unit • Local law enforcement • County coroners/ medical examiners • Local prosecuting agencies (district attorneys)	• Dept. of Health, Div. of Nursing Care Facilities • Attorney General's office, Elder Abuse Unit	• OIG • DOJ/U.S. Attorney's offices • Federal investigative agencies	Attorney General's office, MFCU	Attorney General's office	• Local law enforcement • Local prosecuting agencies (county attorneys)	AoA	Office of State LTC Ombudsman, Dept. of Aging	Area agencies on aging

Note. AoA = U.S. Administration on Aging; CMS = Centers for Medicare & Medicaid Services; Dept. = Department; Div. = Division; DOJ = U.S. Department of Justice; FBI = Federal Bureau of Investigation; LTC = long-term care; LTCOPs = long-term care ombudsman programs; MFCU = Medicaid Fraud Control Units; OIG = U.S. Department of Health and Human Services, Office of Inspector General.
Local law enforcement encompasses police and sheriffs.

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