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Regulation of Nursing Homes - Adequate Protection for the Nation's Elderly.

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COMMENTS

REGULATION OF NURSING HOMES—ADEQUATE PROTECTION FOR THE NATION'S ELDERLY?

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More than one million elderly Americans live in over 23,000 nursing homes which exist in the United States.[1] While both these people and the homes which care for them were largely ignored in the past, public awareness and concern has now increased—principally as a result of revelations of numerous problems and widespread abuses within the homes. Following a fifteen year study, the Senate Special Committee on Aging has concluded that at least half of the nation's nursing homes have one or more serious, life-threatening conditions and are, therefore, sub-standard.[2] The Committee reports that in many cases patients are not treated humanely, and that they frequently encounter abuse and physical mistreatment including negligent and intentional actions which lead to injury or death.[3] Moreover, nursing home residents must often tolerate unsanitary and unsafe conditions, poor food, and generally inadequate health care.[4] Patients are victimized by misappropria-

1. SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, S. REP. NO. 93-1420, 93d Cong., 2d Sess. 15, 20 (1974) [hereinafter cited as INTRODUCTORY REPORT]. The Senate Subcommittee found that nursing home residents have the following characteristics: their average age is 82; they generally are alone (having outlived most relatives and friends); they usually have chronic or crippling disabilities (fewer than half can walk); and a majority are mentally impaired. *Id.* at 16-17. One of the first inventories of nursing homes was taken in 1939; it counted 1,200 facilities. By 1960 there were 9,582 homes. After the medicare and medicaid programs were enacted in 1965, the number of nursing homes and related facilities increased by 140 percent to 23,000. *Id.* at 20-21. According to the Texas Department of Health Resources, as of June 1976, there are 980 licensed nursing homes in Texas with a total of 93,509 beds. It is estimated that the homes have an 80 percent average occupancy rate. Interview with Dayland Parsons, Licensing Officer, Nursing and Convalescent Homes Division, Texas Department of Health Resources, in Austin, Texas, June 17, 1976. Prior to 1976 the Texas Department of Health Resources was referred to as the Texas Department of Health. TEX. REV. CIV. STAT. ANN. art. 4418g(c) (Supp. 1976).

2. STAFF OF SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, 93RD CONG., 2D SESS., NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, SUPPORTING PAPER NO. 1, THE LITANY OF NURSING HOME ABUSES AND AN EXAMINATION OF THE ROOTS OF CONTROVERSY 205 (Comm. Print 1974) [hereinafter cited as SUPPORTING PAPER NO. 1].

3. *Id.* at 169-73, 196-99.

4. *Id.* at 173-80, 183-91. The patients' needs for eye, dental, and foot care are often ignored. *Id.* at 193-96. It is not uncommon for the wrong drugs to be distributed to the residents. It is estimated that the average nursing home patient takes from 4 to 7 different drugs daily, and 20 to 40 percent of these are administered erroneously. STAFF OF SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, 94TH

tion and theft of their personal property and often suffer from profiteering by the homes.[5] Those patients who complain about maltreatment or poor conditions may be subjected to reprisals.[6] These conditions persist despite the expenditure of billions of dollars in public funds[7] and an elaborate system of state and federal regulations.

Several explanations for the lack of progress in improving nursing home conditions exist. The low quality of care is often attributed to staffing problems, particularly the fact that unskilled personnel are used extensively, and that they perform the bulk of the nursing duties.[8] This problem is compounded by physicians' negligence in failing to give adequate attention to the patients.[9] The more plausible explanation, however, is that existing regulatory standards and enforcement devices are inadequate. This inadequacy is at least partially attributable to the weakness of the standards themselves,[10] but it also stems from the ineffectiveness of the enforcement devices. Fines and penalties are seldom imposed, and inspections of nursing homes are often haphazard and lax.[11]

CONG., 1ST SESS., NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, SUPPORTING PAPER NO. 3, DOCTORS IN NURSING HOMES: THE SHUNNED RESPONSIBILITY XV (Comm. Print 1975) [hereinafter cited as SUPPORTING PAPER NO. 3]. *See generally* STAFF OF SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, 94TH CONG., 1ST SESS., NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, SUPPORTING PAPER NO. 2, DRUGS IN NURSING HOMES: MISUSE, HIGH COSTS, AND KICKBACKS (Comm. Print 1975).

5. SUPPORTING PAPER NO. 1, *supra* note 2, at 180-83, 199-204. For discussions of the reimbursement of nursing home costs and how it relates to the quality of patient care, see STAFF OF SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, 94TH CONG., 1ST SESS., NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, SUPPORTING PAPER NO. 9, PROFIT AND THE NURSING HOME: INCENTIVES IN FAVOR OF POOR CARE (Comm. Print 1975); NEW YORK STATE MORELAND ACT COMM., REIMBURSING OPERATING COSTS: DOLLARS WITHOUT SENSE (March 1976); NEW YORK STATE MORELAND ACT COMM., PRUNING THE MONEY TREE (Jan. 1976); Berman, *The Nursing Home Morass: Likelihood of Extradition and Reform*, 17 ARIZ. L. REV. 357 (1975).

6. SUPPORTING PAPER NO. 1, *supra* note 2, at 191-93.

7. Revenues for the nursing home industry reached an estimated $7.5 billion in 1974 with over half coming from governmental sources. Of the public funds used for the reimbursement of nursing home costs, medicare contributed $3.5 million, while medicaid paid $3.7 billion. Private patients paid $3.5 billion. INTRODUCTORY REPORT, *supra* note 1, at 24-25. Through its medicaid program, Texas paid more than $231 million to nursing homes in 1975. TEX. DEP'T PUB. WELFARE, STATISTICS '75, TABLE 20 (1975).

8. INTRODUCTORY REPORT, *supra* note 1, at 8. It is estimated that 80 to 90 percent of the care in nursing homes is provided by untrained aides and orderlies—persons usually paid no more than the minimum wage. *Id.* at 8. *See generally* STAFF OF SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, 94TH CONG., 1ST SESS., NURSING HOME CARE IN THE UNITED STATES: FAILURE OF PUBLIC POLICY, SUPPORTING PAPER NO. 4, NURSING IN NURSING HOMES: THE HEAVY BURDEN (THE RELIANCE ON UNTRAINED AND UNLICENSED PERSONNEL) (Comm. Print 1975).

9. INTRODUCTORY REPORT, *supra* note 1, at 8. *See generally* SUPPORTING PAPER NO. 3, *supra* note 4.

10. *See* INTRODUCTORY REPORT, *supra* note 1, at 53.

11. *Id.* at 76-84.

The remedy for this situation is clear. The standards and enforcement techniques must be improved, existing regulations must be more vigorously enforced, and all persons interested in the problem—enforcement agencies, consumer groups, and nursing home patients—must become more litigious. In addition, arbitration councils and ombudsman programs should be implemented, and alternatives to nursing homes should be considered.

CHARACTERISTICS OF NURSING HOMES

In order to analyze nursing home problems, it is necessary to first consider some general characteristics of the operation and economics of the homes. Almost eighty percent of the homes in the United States are privately owned and are operated for profit; the remainder are operated by non-profit agencies or the government.[12] Both types can be further classified according to the level of care which they provide. As defined in the Social Security Act, skilled nursing facilities are those which offer the highest level of care,[13] while intermediate care facilities are those which accommodate individuals who require medical care on a daily basis, but do not require skilled nursing services.[14]

Generally, nursing homes are reimbursed by payments from the patients' personal resources or through the medicaid and medicare programs.[15] Medicare and medicaid pay for over half of the nation's nursing home costs,[16] and as a result, these programs have become essential to the economic survival of most nursing homes.[17]

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12. *Id.* at 22. Seventy-seven percent of the nation's nursing homes are operated for profit, while 15 percent are managed by non-profit agencies. The remaining 8 percent are operated directly by governmental and state agencies. *Id.* at 22.

13. These facilities offer skilled nursing or rehabilitative services on a 24 hour basis and are defined in 42 U.S.C. § 1395x(j) (1970), *as amended*, (Supp. II, 1972) and at 42 U.S.C. § 1396d(i) (Supp. II, 1972). The federal standards of participation applicable to skilled nursing facilities are set forth in 20 C.F.R. §§ 405.1101-.1137 (1975). The Texas standards are set forth in TEX. DEP'T OF PUB. WELFARE, THE STANDARDS FOR PARTICIPATION—SKILLED NURSING FACILITIES (1969). As of April 1976, there were 216 skilled nursing facilities in Texas. Interview with Gary Allen, Director of Certification Division, Texas Department of Public Welfare, in Austin, Texas, July 12, 1976.

14. "Intermediate care facility" is defined in 42 U.S.C. § 1396d(c) (Supp. III, 1973). Applicable federal regulations are found at 45 C.F.R. §§ 249.12, 250.18-.30 (1975). Texas has two levels of intermediate care, II and III, with standards for each set forth in TEX. DEP'T OF PUB. WELFARE, THE STANDARDS FOR PARTICIPATION—INTERMEDIATE CARE II FACILITY (1969) and in TEX. DEP'T OF PUB. WELFARE, THE STANDARDS FOR PARTICIPATION—INTERMEDIATE CARE III FACILITY (1969). As of April 1976, there were 868 intermediate care facilities in Texas. Interview with Gary Allen, Director of Certification Division, Texas Department of Public Welfare, in Austin, Texas, July 12, 1976.

15. INTRODUCTORY REPORT, *supra* note 1, at 25.

16. *Id.* at 25. The federal government also assists nursing homes through more than 50 programs other than medicare and medicaid. *Id.* at 24-26.

17. Of the 980 nursing homes in Texas, only approximately 43 do not participate in the medicaid program. Interview with Dayland Parsons, Licensing Officer, Nursing and

Of the two programs, medicaid contributes the greater share toward nursing home costs.[18] Medicaid is a joint state and federal grants-in-aid program administered by the Department of Health, Education, and Welfare and by each participating state.[19] Those states which choose to participate must submit a plan acceptable to HEW, and within that plan designate a "single state agency" to administer the program.[20] That agency is required both to establish and maintain quality-of-care standards for the state's nursing homes and to enforce federal statutes and regulations.[21] Once a state's plan is approved, the federal government pays from 50 to 83 percent of the costs[22] incurred by the state in providing medical assistance to indigents, a term which includes qualified nursing home patients.[23] With medicaid funds, the states reimburse both skilled and intermediate nursing facilities for services rendered to eligible individuals under payment schedules adopted by the states, but subject to HEW guidelines.[24]

In contrast to the medicaid program, medicare plays a relatively minor role in the payment of nursing home costs.[25] Medicare is a federal health insur-

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Convalescent Homes Division, Texas Department of Health Resources, in Austin, Texas, June 17, 1976.

18. INTRODUCTORY REPORT, *supra* note 1, at 25-26.

19. 42 U.S.C. §§ 1396-1396i (1970), *as amended*, (Supp. III, 1973) (outline of the medicaid programs). *See generally* Schaak v. Schmidt, 344 F. Supp. 99, 103 (E.D. Wis. 1971) (participation by the states in the medicaid program is voluntary). If the state elects to participate, however, "it must comply with the federal statutes and regulations to remain eligible for federal funds." *Id.* at 103.

20. 42 U.S.C. § 1396a (1970), *as amended*, (Supp. III, 1973). The "single state agency" administering medicaid may delegate the responsibility for inspecting the homes for compliance with state and federal standards to another agency. 42 U.S.C. § 1396a(33)(B) (Supp. III, 1973). In Texas the Department of Public Welfare is the state agency designated to administer the Texas medicaid program. TEX. REV. CIV. STAT. ANN. art. 695j-1 (Supp. 1976). The Texas Department of Health Resources is the state's licensing and survey, or inspection, agency. TEX. REV. CIV. STAT. ANN. art. 4442c, § 2(d) (Pamphlet Supp. 1975).

21. 42 U.S.C. § 1396a(a)(9) (1970), *as amended*, (Supp. III, 1973).

22. 42 U.S.C. § 1396b (1970), *as amended*, (Supp. III, 1973). The percentage paid by the federal government depends on the per capita income of the state. From July 1975 through June 1977, the federal government will pay 63.59 percent of the medicaid costs for Texas. 3 CCH MEDICARE AND MEDICAID GUIDE ¶ 14,905 (1975).

23. 42 U.S.C. § 1396 (1970); *id.* § 1396a(a)(10); 45 C.F.R. §§ 248.3, .10 (1975) (describes persons eligible for medicaid). The eligibility criteria for the Texas medicaid program are set forth in TEX. DEP'T OF PUB. WELFARE, MEDICAID ELIGIBILITY § 2100 (Nov. 1975), and in TEX. DEP'T OF PUB. WELFARE MEDICAL CARE MANUAL OF SERVICES § 2000 (Jan. 1975). Once an individual qualifies for medicaid, he has complete freedom to choose the nursing home he prefers. 42 U.S.C. § 1396a(a)(23) (1970), *as amended*, (Supp. II, 1972); 45 C.F.R. § 249.20 (1975).

24. 42 U.S.C. § 1396a(a)(30) (1970), *as amended*, (Supp. II, 1972); 45 C.F.R. § 250.30(b) (1975). By July 1, 1976, all states were required to adopt the reasonable cost-related reimbursement procedure rather than reimbursement on a flat-fee basis. 42 U.S.C. § 1396a(a)(13)(E) (Supp. II, 1972). The medicaid reimbursement is payment in full. 45 C.F.R. § 250.30(a)(7) (1975).

25. INTRODUCTORY REPORT, *supra* note 1, at 25-26.

ance program designed to insure adequate health care to those persons who are at least 65 years old or disabled, and it is administered exclusively by HEW.[26] Only skilled nursing facilities are reimbursed by medicare, and payment is limited to care for 100 days or less.[27] The limited coverage of medicare has prevented it from becoming as integral a part of nursing home financing as the medicaid program.

STANDARDS AND ENFORCEMENT DEVICES APPLICABLE TO NURSING HOMES

Standards

Nursing homes which participate in the medicare or medicaid programs are subject to a variety of local, state, and federal regulations. At the very least, nursing facilities must comply with those municipal ordinances and codes which govern health, sanitation, safety, fire prevention, and zoning. Moreover, in order to operate at all, homes must obtain state licenses.[28] Each state has a licensing agency which establishes and enforces its own standards.

The Department of Health Resources is the licensing agency for Texas; it has statutory authority to promulgate minimum standards which the nursing homes must meet in order to be licensed.[29] The standards, which must be

26. 42 U.S.C. §§ 1395-1395pp (1970), *as amended*, (Supp. III, 1973). Public agencies or private organizations such as insurance carriers can be designated by HEW as "fiscal intermediaries" which are responsible for the processing of medicare claims for reimbursement. 42 U.S.C. § 1395h (1970), *as amended*, (Supp. III, 1973).

27. 42 U.S.C. § 1395d(a)(2) (1970). In order for medicare to pay for the full 100 days, the patient must have suffered from a continuous "spell of illness" and must have required more than "custodial care." 42 U.S.C. § 1395d (1970), *as amended*, (Supp. II, 1972); *see, e.g.*, Wilson v. Weinberger, 371 F. Supp. 1358, 1360-61 (E.D. Tenn. 1973); Reading v. Richardson, 339 F. Supp. 295, 299-300 (E.D. Mo. 1972).

28. Most states require that individuals or corporations first obtain a "certificate of need" from the appropriate state agency before a nursing home is constructed. In Texas, in order to expand or build a nursing home, one must apply to the Texas Health Facilities Commission for a "certificate of need." TEX. REV. CIV. STAT. ANN. art. 4418h, §§ 3.01(a)(1)-(4) (Supp. 1976); *see* Attoma v. State Dept. of Social Welfare, 270 N.Y.S.2d 167, 171-72 (Sup. Ct. 1966) (upholding constitutionality of statute requiring that license applicant establish "need" for new facility as a reasonable exercise of police power). For a discussion of "certificate of need" requirements see Murray & Glassberg, *Long-Term Health Care for the Elderly: The Challenge of the Next Decade*, 39 ALBANY L. REV. 617 (1975). For cases holding that denial of a license is a valid exercise of state police power, *see, e.g.*, State *ex rel.* Eagleton v. Patrick, 370 S.W.2d 254, 257 (Mo. 1963); Tepper v. Dep't of Social Welfare, 292 N.Y.S.2d 509, 513 (Sup. Ct. 1968).

29. TEX. REV. CIV. STAT. ANN. art. 4442c, §§ 2(d), 7 (1966). In addition to the requirement that the nursing homes themselves be licensed, Texas also requires administrators to be licensed. TEX. REV. CIV. STAT. ANN. art. 4442d (Supp. 1976). *See generally* Culverhouse v. Atlanta Ass'n for Convalescent Aged Persons, Inc., 194 S.E.2d 299, 301 (Ga. Ct. App. 1972) (failure of administrator to meet licensing requirement was a defense in an action by the nursing home for payment of services rendered); Holly v. Bates, 81 A.2d 151, 154 (N.J. 1951) (nursing home denied license to operate because the administrator had twice violated laws relating to unauthorized practice of medicine).

met annually, deal primarily with the physical construction of the homes,[30] sanitation and safety,[31] and with personnel and staffing requirements.[32] One section, however, is devoted exclusively to the humane treatment of patients.[33] That section provides for such basic patient rights as the freedom from abuse and punishment, the freedom to manage personal finances, the right to send and receive mail unopened, and the right to receive visitors frequently.[34] As in most states, failure to comply with these standards is grounds for denial or revocation of a license to operate.[35]

In addition to complying with local ordinances and state licensing requirements, nursing homes which receive medicare and medicaid funds must also meet all applicable federal statutes and regulations.[36] Before a nursing home can be reimbursed by medicare or medicaid, it must first be certified for participation in the program.[37] A nursing home can be certified only after it has been found to be in compliance with all relevant federal and state statutes and regulations, a finding made by the appropriate state agency,[38] or by HEW if the home receives medicare.

The federal statutes and regulations with which the homes must comply vary with the level of care offered. Generally, the standards which apply to skilled nursing homes are more detailed and stringent than those governing intermediate care facilities, but their overall scope is basically the same. The regulations in both cases concentrate primarily on patient care, medical and social services, record maintenance, and staffing requirements,[39] and not on the physical aspects of the home itself.[40]

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30. TEX. DEP'T OF HEALTH RESOURCES, MINIMUM STANDARDS FOR NURSING HOMES, § V, at 3-12 (1969).

31. *Id.* §§ V(C), (D), (H), (K), at 5-11; *id.* § XI(E), at 24; *id.* §§ XII(A)-(C), at 24-25.

32. *Id.* § VI, at 12-15.

33. *Id.* § XIII, at 26.

34. *Id.* § XIII, at 26.

35. *Id.* § XIII(B), at 26.

36. 20 C.F.R. § 405.1120 (1975); 45 C.F.R. § 249.12(a)(1)(vii) (1975).

37. 42 U.S.C. § 1395f(a) (1970), *as amended*, (Supp. III, 1973); 42 U.S.C. § 1396i (Supp. II, 1972); 20 C.F.R. §§ 405.1902-.1908 (1975); 45 C.F.R. § 250.100 (1975).

38. 42 U.S.C. § 1395aa(a) (1970), *as amended*, (Supp. III, 1973); 42 U.S.C. § 1396a(a)(33)(B) (Supp. III, 1973). The Texas Department of Health Resources is the state agency which surveys nursing homes to determine whether they should be certified for participation in medicaid or medicare. The department then forwards its recommendation to the State Department of Public Welfare if a home is reimbursed by medicaid or to HEW if a home is reimbursed by medicare. Interview with Gordon Bishop, Zone Administrator, Texas Department Health Resources, in San Antonio, Texas, July 13, 1976.

39. *See generally* 20 C.F.R. §§ 405.1101-.1137 (1975) (regulations for skilled nursing facilities); 45 C.F.R. § 249.12 (1975) (regulations for intermediate nursing facilities).

40. Compliance with the Life Safety Code is an important aspect of physical building requirements. The Code is aimed at the prevention of fires and governs such things as alarm and sprinkler systems and fire escapes. Both intermediate and skilled

In addition to meeting the federal standards, nursing homes which are reimbursed by medicaid must also comply with any standards adopted by the state agency administering the medicaid program.[41] The Texas Department of Public Welfare, the administrator of the medicaid program for Texas,[42] has established standards for skilled and intermediate facilities. These standards, for the most part, incorporate and elaborate on the federal regulations, but in some instances add additional requirements.[43] Generally, noncompliance with the state or federal regulations provides grounds for decertification of a home and termination of its medicare or medicaid contract or provider agreement.[44] In addition, some states impose fines for violations of regulations and standards.[45]

Nursing Home Patients' Bill of Rights

An important aspect of the regulations for both the intermediate and skilled care homes are the provisions concerning patients' rights.[46] While these regulations may seem so basic as to be unnecessary, they are nevertheless quite important in situations where a person has been institutionalized because of mental or physical impairments. The primary focus of these regulations is to ensure that the patient is informed of all actions which might affect him.[47] The patient must be fully informed of his rights, the rules which will affect his conduct, the services available to him in the facility, his medical condition, and must be given reasonable notice of his transfer or discharge from the facility.[48]

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care facilities must meet the requirements of the Life Safety Code. 20 C.F.R. § 405.1134 (1975); 45 C.F.R. § 249.12(a)(5) (1975).

41. *See, e.g.*, TEX. REV. CIV. STAT. ANN. art. 695j-1, § 3(14) (Supp. 1976) (empowers the Texas Department of Public Welfare to adopt regulations ensuring compliance with federal laws).

42. *Id.* art 695j-1, § 3.

43. *See generally* TEX. DEP'T OF PUB. WELFARE, STANDARDS FOR PARTICIPATION-INTERMEDIATE II FACILITY (1969); TEX. DEP'T OF PUBLIC WELFARE, STANDARDS FOR PARTICIPATION-INTERMEDIATE III FACILITY (1969); TEX. DEP'T OF PUB. WELFARE, STANDARDS FOR PARTICIPATION-SKILLED NURSING FACILITY (1969).

44. 42 U.S.C. § 1395cc(b)(2) (1970), *as amended*, (Supp. III, 1973); 20 C.F.R. § 405.614 (1975); 45 C.F.R. § 249.33(a)(4) (1975). In order to satisfy constitutional due process requirements, nursing homes must be given notice and a hearing before their medicaid provider agreements are cancelled. *See, e.g.*, Maxwell v. Wyman, 458 F.2d 1146, 1152 (2d Cir. 1972); Coral Gables Convalescent Home, Inc. v. Richardson, 340 F. Supp. 646, 650 (S.D. Fla. 1972). It has also been held that once a home has been decertified, the residents of that home who received medicaid benefits are entitled to administrative hearings and cannot be removed from the nursing home until a final disposition is made. Kane v. Parry, 371 N.Y.S.2d 605, 606 (Sup. Ct. 1975).

45. *See* Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304, 342 (1975).

46. 20 C.F.R. § 405.1121(k) (1975). Patient rights for intermediate care facilities became effective June 28, 1976. 41 Fed. Reg. 12883 (1976).

47. 20 C.F.R. §§ 405.1120(k)(1)-(4) (1975).

48. *Id.*

The regulations also contain provisions which help the patients maintain control over their personal affairs; they are allowed to manage their own finances[49] and to associate in privacy with persons of their choice.[50] Additionally, nursing home employees are required to treat patients with respect, and are forbidden from physically or mentally abusing patients.[51] Finally, one of the most important regulations requires that patients be encouraged and assisted in exercising their rights and voicing their grievances without fear of reprisals.[52] As with all other applicable federal standards, noncompliance with patients' rights regulations can result in decertification and termination of provider agreement or contracts.[53]

Failure of Standards

While the body of regulatory material concerning nursing home standards appears to be adequate, a close examination reveals numerous weaknesses. The primary shortcoming of both the state and federal regulations is that they do not ensure or adequately measure the quality of care rendered in the homes; they are so vague or ambiguous that they defy enforcement. Both sets of standards frequently use such imprecise terms as "sufficient," "reasonable," "substantial progress," and "unreasonable hardship" in describing requirements for nursing care.[54] Standards worded in this manner offer little guidance to nursing homes or inspection teams, and they make compliance and enforcement difficult.[55] This lack of precision in the standards causes vital decisions to be based on the subjective judgments of inspection team members, judgments which may or may not adequately evaluate the true state of patient care in the nursing home.[56]

49. *Id.* § 405.1120(k)(6). *See* 9 CLEARINGHOUSE REVIEW Case 17,728 at 886 (April 1976) (nursing home was prohibited from delaying or opening patients' mail and from interfering with funds such as Social Security disability payments).

50. 20 C.F.R. §§ 405.1120(k)(11), (14) (1975). Patients must be assured confidential treatment of their personal and medical records. *Id.* § 405.1120(k)(8). They also must be allowed to retain and use personal clothing and possessions. *Id.* § 405.1120(k)(13).

51. *Id.* §§ 405.1120(k)(7), (9) (1975).

52. *Id.* § 405.1120(k)(5) (1975).

53. *Id.* § 405.614 (1975); 45 C.F.R. § 249.33(a)(4) (1975).

54. *See, e.g.*, 20 C.F.R. § 405.1124 (1975) ("sufficient" number of qualified nursing personnel); *id.* § 405.1130 (facility has "satisfactory arrangements for identifying medically related social and emotional needs of the patients"); *id.* § 405.1134(a) (Secretary may waive provisions of the Life Safety Code which would result in "unreasonable hardship" on a facility); 45 C.F.R. § 249.12(a)(6)(i) (1975) (residents' rooms are to be "conveniently located near adequate toilet and bathing facilities"); *id.* § 249.12(a)(7)(ii) ("staff member suited by training or experience in food management or nutrition is responsible" for planning menus).

55. INTRODUCTORY REPORT, *supra* note 1, at 46-54; NEW YORK STATE MORELAND ACT COMM., REGULATING NURSING HOME CARE: THE PAPER TIGERS 10-11, 31-40 (Oct. 1975).

56. NEW YORK STATE MORELAND ACT COMM., REGULATING NURSING HOME CARE: THE PAPER TIGERS 31-40 (Oct. 1975).

The effectiveness of the standards and regulations is also impaired by the fact that the inspection teams are allowed to waive certain requirements which nursing homes must normally meet. For example, HEW permits skilled nursing homes to be certified even when they fail to meet current licensing standards, provided they formerly met such standards.[57] Additionally, waivers of the requirements of the Life Safety Code[58] and bedroom dimensions[59] are allowed if corrections would work unreasonable hardships on the facilities, and the patients are not adversely affected thereby. The inspection teams are authorized to permit these waivers, as well as others,[60] in their unlimited discretion. Frequent use of the waivers inevitably results in deterioration of the quality of care.

Standards have also failed because of actions by HEW. In setting out regulations, HEW has often eliminated or significantly changed provisions which Congress considered essential to patient care.[61] For example, Congress authorized a waiver of the requirement of a full-time registered nurse for skilled facilities in rural areas. HEW regulations lowered standards to 5-day-a-week coverage for all skilled nursing facilities, an action which made the entire nation a "rural area."[62] HEW has also flatly refused to issue even minimum ratios for attendants per patient[63] and has deleted significant provisions which related to physician, nursing, and dietary services, and the control and distribution of drugs.[64] Further, the "patient bill of rights" was substantially weakened by failing to provide enforcement provisions for it.

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57. 20 C.F.R. § 405.1120(a)(3) (1975).

58. *Id.* § 405.1134(a); 45 C.F.R. § 249.12(a)(5)(ii) (1975). *See, e.g.*, Miramichi Nursing Home v. Lavine, 349 N.Y.S.2d 782, 785-86 (Sup. Ct. 1973) (waiver of Life Safety Code not allowed where it would not adversely affect health and safety of patients); Kruger v. Ingraham, 348 N.Y.S.2d 180, 182 (Sup. Ct. 1973) (waiver of Life Safety Code requirements allowed because it did not adversely affect the health and safety of the patients).

59. 20 C.F.R. § 405.1134(e) (1975); 45 C.F.R. § 249.12(a)(6)(A) (1975).

60. *See, e.g.*, 20 C.F.R. §§ 405.604, .1902, .1911 (1975); 45 C.F.R. §§ 249.12(a)(6)(B)(ix), .33(i) (1975).

61. *See generally* INTRODUCTORY REPORT, *supra* note 1, at 35-36, 51-53; SPECIAL COMM. ON AGING, DEVELOPMENTS IN AGING: 1973 AND JAN.-MAR. 1974, S. REP. NO. 93-846, 93rd Cong., 2d Sess. 50-79 (1974).

62. SENATE SPECIAL COMM. ON AGING, DEVELOPMENTS IN AGING: 1973 AND JAN.-MAR. 1974, S. REP. NO. 93-846, 93rd Cong., 2d Sess. 50 (1974). This regulatory change, as well as others, was the result of a congressional mandate in 1972 to unify the medicare and medicaid standards for skilled nursing facilities. The congressional intent of this action was clearly to upgrade standards, not to weaken them. *Id.*

63. INTRODUCTORY REPORT, *supra* note 1, at 49.

64. *See generally* SENATE SPECIAL COMM. ON AGING, DEVELOPMENTS IN AGING: 1973 AND JAN.-MAR. 1974, S. REP. NO. 93-846, 93rd Cong., 2d Sess. 50-79 (1974). In addition to ignoring congressional intent, HEW has also shown substantial favoritism to the nursing home industry in establishing regulations. It was discovered that HEW distributed drafts of proposed regulations to the nursing home owners and associations 6 months prior to their publication, while consumer groups, the public, and members of Congress were given only 30 days to review the proposals. *Id.* at 53-58.

These omissions and modifications, allegedly the result of "needed flexibility,"[65] are particularly significant since they render many provisions useless.

Enforcement Devices

Several enforcement devices can be utilized in the event that nursing homes do not comply with the various standards. State licensing agencies can revoke or suspend licenses for non-compliance,[66] and other state and federal agencies are empowered to withdraw certification from nursing facilities, revoke their provider agreements, and thereby deprive them of medicaid and medicare funds.[67] Some state enforcement agencies are also allowed to impose fines and to seek injunctive relief against nursing homes which violate regulations and standards.[68]

Generally, compliance or noncompliance with standards is determined by inspection and review teams of the state's administrative or licensing agencies. HEW has, for the most part, left inspection and enforcement of its requirements to the states,[69] despite federal reimbursement for almost one-half of the nation's total nursing home bill. Usually the same state agency which issues licenses to nursing homes also surveys them for compliance with state and federal standards. Over-all surveys to determine if nursing homes meet federal requirements typically take place once a year and are conducted by a group of health care specialists.[70] When the inspection has been completed, a report of deficiencies is presented to the nursing home which must then submit a plan for correction.[71] Follow-up visits are made by the inspection teams to determine whether the deficiencies have been corrected. Based on its findings, the team decides whether to recommend the facility for certification.[72] Within ninety days after the completion of the survey, the report

65. *Id.* at 72-73.

66. *See, e.g.*, TEX. REV. CIV. STAT. ANN. art. 4442c § 6 (1966); TEX. DEP'T OF HEALTH RESOURCES, MINIMUM STANDARDS FOR NURSING HOMES, § XIII(B) (1969).

67. 20 C.F.R. § 405.614 (1975); 45 C.F.R. § 249.33(a)(4) (1975).

68. *See, e.g.*, TEX. REV. CIV. STAT. ANN. art. 4442c, § 11 (1966). Enforcement agencies can also seek criminal penalties for nursing home operators who make fraudulent statements in an application for benefits, participate in kickback schemes or bribes, or make false representations concerning the requirements of social security. 42 U.S.C. § 1307(a) (1970); *id.* § 1395nn (Supp. III, 1973); *id.* § 1396h (Supp. II, 1972). *See* People v. Balmer, 17 Cal. Rptr. 612, 614-15 (Super. Ct. 1961) (criminal statutes for the protection of public health including statutes pertaining to sanitary conditions in nursing homes are an appropriate exercise of state's police power).

69. 42 U.S.C. § 1395aa(a) (1970), *as amended*, (Supp. III, 1973); *id.* §§ 1396a(a)(30), (31), (33) (1970), *as amended*, (Supp. III, 1973); 20 C.F.R. § 405.1902(a) (1975); 45 C.F.R. § 250.100 (1975).

70. 42 U.S.C. § 1395aa(a) (1970), *as amended*, (Supp. III, 1973); 42 U.S.C. § 1396a(a)(33) (Supp. III, 1973); 20 C.F.R. § 405.1904 (1975).

71. 20 C.F.R. §§ 405.1907(a),(b) (1975); 45 C.F.R. § 249.33(a)(4)(B) (1975).

72. 20 C.F.R. § 405.1902(a) (1975); 45 C.F.R. §§ 249.33(a)(1)(i), 250.100(c) (1975). Facilities may be certified in full compliance, or if deficiencies exist, in only

of the inspection team must be made available to the public at local welfare and health offices.[73]

The federal government also requires that nursing homes be monitored by medical review teams, utilization review committees, program review teams, and professional standards review organizations. As a part of its medicaid program, each state must conduct medical reviews of both skilled and intermediate care facilities.[74] The team, which is made up of one or more physicians and other appropriate health care personnel,[75] must examine the adequacy of care provided, the necessity for each patient's continued presence in the nursing home, and the availability of alternative modes of care.[76] The team's report, containing its conclusions and recommendations, is sent to the agency which administers the state's medicaid program.[77]

Both skilled and intermediate homes are also required to have utilization review committees.[78] Utilization review is conducted by an internal staff committee of the nursing home composed of two or more physicians, or by an external group established by a local medical society.[79] The committee's primary duty is to evaluate the level of care given each patient, and it is also required to produce a medical care evaluation study dealing with both quality of care and utilization efficiency.[80] Those homes which receive medicare funds are also checked by professional review teams which both analyze statistical data on program utilization and review particular cases in order to detect abuses within the program due to overpricing and delivery of inferior quality care.[81] Professional standards review organizations, which have not yet been implemented, will review medicare and medicaid paid-for services

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partial compliance. 20 C.F.R. § 405.1902(b) (1975); 45 C.F.R. § 249.33(a)(4) (1975).

73. 42 U.S.C. § 1395aa(a) (Supp. III, 1973); 45 C.F.R. § 250.100(c)(3) (1975). It has been held that the Freedom of Information Act also requires nursing home inspection reports to be publicly disclosed. Schechter v. Weinberger, 506 F.2d 1275, 1277 (D.C. Cir 1974); Stretch v. Weinberger, 495 F.2d 639, 641 (3d Cir. 1974).

74. 42 U.S.C. §§ 1396a(a)(26), (31) (1970), *as amended*, (Supp. III, 1973); 45 C.F.R. § 250.23(a)(4) (1975); *see* NATIONAL SENIOR CITIZENS LAW CENTER, THE NURSING HOME LAW HANDBOOK 32 (1975).

75. 45 C.F.R. § 250.23(a)(2)(i) (1975).

76. *Id.* § 250.23(a)(3)(v) (1975).

77. *Id.* §§ 250.23(a)(4)(i)-(iii) (1975); *see* NATIONAL SENIOR CITIZENS LAW CENTER, THE NURSING HOME LAW HANDBOOK 32 (1975).

78. 42 U.S.C. § 1395x(k) (1970), *as amended*, (Supp. III, 1973); *id.* §§ 1396a(a)(30), 1396b(g), 1396b(i)(4), *as amended*, (Supp. III, 1973); 20 C.F.R. § 405.1137 (1975); 45 C.F.R. § 250.19 (1975).

79. 20 C.F.R. § 405.1137(b)(1) (1975); 45 C.F.R. § 250.19(a)(i)(ii)(A) (1975).

80. 20 C.F.R. § 405.1137 (1975); 45 C.F.R. § 250.19 (1975).

81. 42 U.S.C. § 1395y(d)(4) (Supp. III, 1973); *see* NATIONAL SENIOR CITIZENS LAW CENTER, THE NURSING HOME LAW HANDBOOK 29 (1975). In Texas, the medical, utilization, and program reviews are all conducted by a single team from the Department of Public Welfare. Interview with Keats Brazell, Assistant to Chief of Medical Social Services, Texas Department of Public Welfare, in Austin, Texas, May 24, 1976.

of local health care providers for quality of care, medical necessity, and availability of more economical modes of treatment.[82]

The conditions of nursing homes and the quality of patient care are further reviewed by the patient's personal physician and his social worker. Federal regulations place great reliance on physicians in determining whether adequate health care is provided by the nursing homes.[83] Initially, a physician must certify that a patient is in need of nursing home care before the home can be reimbursed by medicaid or medicare.[84] Within the nursing homes, the doctors are key figures in both over-all policy and clinical decisions.[85] The physicians' orders for the care of patients often determine their day-to-day treatment. The medicaid social workers are also important figures in nursing homes since they are required to provide protective services for the residents and must report cases of poor patient care, abuses, and neglect to their supervisors.[86]

Failure of Enforcement Devices

Although the review and enforcement process appears to be structurally sound, the large number of seriously substandard homes still in existence demonstrates that it is not accomplishing its objective.[87] Evidence indicates that licenses are rarely revoked, and that decertification or imposition of fines are infrequent.[88] Inspections and reviews are random and lax, and enforcement by doctors and social workers is largely ineffective.[89]

Various explanations have been set forth for the failure of the enforcement procedures, but the primary problem appears to be with the inspections. Nursing home inspections are inefficient for several reasons: the inspection teams are understaffed; advance notices of inspections are sent to facilities; inspections are infrequent; they concentrate on the physical plant rather than on patient care; inspections are often cursory and ritualistic; responsibility

82. *See* 42 U.S.C. § 1320c-1-19 (Supp. III, 1973); NATIONAL SENIOR CITIZENS LAW CENTER, THE NURSING HOME LAW HANDBOOK 29-30, 32 (1975).

83. *See* Regan, *Quality Assurance Systems in Nursing Homes*, 53 J. URBAN L. 153, 167-71 (1975).

84. 42 U.S.C. § 1395f(a)(2)(C) (1970), *as amended*, (Supp. III, 1973); 20 C.F.R. § 405.1123 (1975); 20 C.F.R. § 405.1632 (1975).

85. *See, e.g.*, 42 U.S.C. § 1395x(j)(2) (1970); 42 U.S.C. § 1396a(a)(28) (1970), *as amended*, (Supp. III, 1973); 20 C.F.R. § 405.1123(b) (1975).

86. TEX. DEP'T OF PUB. WELFARE, MEDICAL CARE MANUAL OF SERVICES § 3140 (April 1975).

87. SUPPORTING PAPER NO. 1, *supra* note 2, at 205.

88. *See* INTRODUCTORY REPORT, *supra* note 1, at 76-84. *See generally* NEW YORK STATE MORELAND ACT COMM., REGULATING NURSING HOME CARE: THE PAPER TIGERS 1-12, 43 (Oct. 1975).

89. *See* INTRODUCTORY REPORT, *supra* note 1, at 76-91. *See generally* NEW YORK STATE MORELAND ACT COMM., REGULATING NURSING HOME CARE: THE PAPER TIGERS 1-12 (Oct. 1975).

for inspections is frequently fragmented among different state agencies; and inspection teams and agencies are subject to political influences.[90]

The inspection process is also hindered by standards which are general and ambiguous and therefore offer little guidance in the detection of deficiencies. The standards are phrased so as to make compliance with requirements easy and findings of noncompliance difficult.[91] Moreover, inspection teams are required to evaluate the adequacy of conditions and care when they are not sufficiently trained to make such judgments. This is particularly true in the case of technical medical requirements.[92] As a result of inadequate inspections and sporadic enforcement, many deficiencies are undetected or, if discovered, are not corrected. As such, a large number of homes containing deficiencies are licensed and certified[93] while the quality of patient care remains low.

Reluctance on the part of agencies to decertify facilities and to revoke their licenses is generally attributed to the severity of these remedies.[94] Enforcement agencies typically maintain that these solutions work more harm than good since there is a shortage of nursing facilities, and since they force patients to transfer to other homes.[95] State agencies are likewise hesitant to institute proceedings to revoke a facility's license because of the cumbersome and expensive procedures involved.[96] While these reasons for inaction may have some validity, they should not become blanket excuses for nonenforcement.

The enforcement of standards and regulations has not been aided to any significant extent by physicians or social workers. Despite their importance in assuring high quality medical care in nursing homes, doctors' visits are generally infrequent, and they have allowed their responsibilities for the patients' needs to fall upon untrained personnel.[97] Medicaid social workers, in turn, often find their workload too heavy[98] to allow them to adequately fulfill their

90. INTRODUCTORY REPORT, *supra* note 1, at 76-84.

91. *Id.* at 52-53.

92. *See generally* NEW YORK STATE MORELAND ACT COMM., REGULATING NURSING HOME CARE: THE PAPER TIGERS 35-43 (Oct. 1975).

93. In 1974, 4,307 of the nation's 7,318 skilled nursing facilities were certified despite deficiencies. Of these, 28 percent either had no plans for correction on file, or the plans were incomplete. INTRODUCTORY REPORT, *supra* note 1, at 78.

94. *Id.* at 76; *see* Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304, 332-39 (1975).

95. INTRODUCTORY REPORT, *supra* note 1, at 76; *see* Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304, 332-39 (1975).

96. *See, e.g.*, TEX. REV. CIV. STAT. ANN. art. 4442c, §§ 6, 10 (1966).

97. SUPPORTING PAPER NO. 3, *supra* note 4, at 320-25; Regan, *Quality Assurance Systems in Nursing Homes*, 53 J. URBAN L. 153, 167-71 (1975).

98. It is estimated that each medicaid social worker in Texas is responsible for an average of 275 nursing home patients living in four to eight homes. Interview with Keats Brazell, Assistant to Chief of Medical Social Services, Texas Department of Public Welfare, in Austin, Texas, May 24, 1976.

duty of monitoring the quality of patient care.[99] As a result of the unavailability of doctors and social workers in nursing homes, many of the patients' needs are left unmet.

PROPOSALS

Litigation by Nursing Home Residents

It should be mentioned initially that participation in any type of suit by a nursing home resident is not an easy matter. The patient is generally sick, poor, and uninformed so access to legal assistance is difficult to obtain. Moreover, patients often fail to pursue their causes of action because of fear of retaliation by the nursing homes. For these reasons, civil litigation by residents may not always be an effective means of redress.

It has been established that nursing homes are liable in tort for injuries sustained by residents as a result of negligent or intentional acts by the homes' employees. The courts have recognized that the owners of nursing homes are under a duty to exercise reasonable care in avoiding injury to patients, with the reasonableness of such care being assessed in light of the patient's physical and mental condition.[100]

The leading case in which recovery was allowed on a tort basis is *Big Town Nursing Home, Inc. v. Newman.*[101] There, a nursing home was held liable for false imprisonment after detaining the plaintiff for fifty-one days when no court order for his commitment existed. The plaintiff was placed in a ward with insane persons, alcoholics, and drug addicts, and was not allowed to contact anyone outside of the home. This was said to be in utter disregard of the patient's rights, and was held to entitle him to exemplary damages.[102]

Causes of action based on contract law seem to be limited for nursing home patients. A nursing home resident whose care is funded by medicaid or medicare, however, may be successful in a suit as a third-party beneficiary of the provider agreement between the nursing home and the federal or state government.[103] Although there appear to be no cases in which nursing home residents have sued as third-party beneficiaries,[104] the right of the patients

99. *See, e.g.*, TEX. DEP'T OF PUB. WELFARE, MEDICAL CARE MANUAL OF SERVICES § 3000 (April 1975).

100. *See, e.g.*, Facey v. Merkle, 148 A.2d 261, 265 (Conn. 1959); Dusine v. Golden Shores Convalescent Center, Inc., 249 So. 2d 40, 42 (Fla. Dist. Ct. App. 1971); Lagrone v. Helman, 103 So. 2d 365, 367-68 (Miss. 1958); Big Town Nursing Home, Inc. v. Newman, 461 S.W.2d 195, 197 (Tex. Civ. App.—Waco 1970, no writ). For a discussion of the cases dealing with the liability of nursing home owners for injuries or death of patients, see Annot., 70 A.L.R.2d 366 (1960).

101. 461 S.W.2d 195, 197 (Tex. Civ. App.—Waco 1970, no writ).

102. *Id.* at 197.

103. *See* Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304, 352 (1975).

104. *Id.* at 352.

to bring such an action has been indirectly recognized in *Seneca Nursing Home v. Kansas State Board of Social Welfare*.[105] It was held there that nursing home owners, as recipients of payments under the Social Security Act, had standing for themselves and for those served by them to assert denials of rights guaranteed by the Social Security Act.[106] It could be argued that this holding confers standing to nursing home patients themselves as third-party beneficiaries. The right of other intended beneficiaries of public contracts, such as utility users and indigent persons unable to pay for medical care, to sue as third-party beneficiaries has been upheld.[107]

Nursing home residents might also recover on a breach of warranty theory.[108] Residents could logically assert that the nursing homes impliedly warrant compliance with applicable federal and state regulation through their contracts with the patients. When this implied warranty is breached, residents arguably are entitled to contract remedies such as declaratory judgment, specific performance, and damages.[109] Nursing home residents should also look to landlord-tenant cases for potential remedies when an analogous relationship exists between the patients and nursing home administrators.[110]

Direct actions by nursing home residents to implement federal and state regulations may present standing problems, since neither the federal or state regulations confer standing on nursing home residents.[111] It could, however, be argued that the regulations which deal with patients' rights impliedly give rise to private causes of action by the patients, since the regulations are designed to protect them.[112]

Although the federal regulations do not specifically confer standing on nursing home residents, several cases brought by patients have recognized their rights under federal nursing home regulations.[113] Following the argu-

105. 490 F.2d 1324 (10th Cir.), *cert. denied*, 419 U.S. 841 (1974) (nursing home owner sought declaratory judgment concerning eligibility for services provided under medicare and medicaid).

106. *Id.* at 1328-29.

107. *See, e.g.*, Saine v. Hospital Authority, 502 F.2d 1033, 1034 (5th Cir. 1974); Euresti v. Stenner, 458 F.2d 1115, 1118 (10th Cir. 1972).

108. Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304, 353 (1975).

109. *Id.* at 354-55.

110. Cohen, *Long-Term Care: A Challenge to Concerted Legal Techniques*, 2 OHIO N.L. REV. 642, 676-77 (1975).

111. *But see* Roberts v. Brian, 98 Cal. Rptr. 50, 53 (1971) (nursing home resident compelled state agency to pay for services required under state medical assistance program).

112. NATIONAL SENIOR CITIZENS LAW CENTER, THE NURSING HOME LAW HANDBOOK 21 (1975).

113. *See* 9 CLEARINGHOUSE REVIEW Case 17,728 at 886 (April 1976) (patient's right to receive mail unopened upheld); *id.* Case 16,338 at 788 (Mar. 1976) (patient entitled to notice prior to reduction of medicaid benefits and prior to transfer to another facility); *id.* Case 15,507 at 268 (Aug. 1975) (upholding patient's right to manage own funds, seek counsel, and to adequate and proper health care); 5 *id.* Case 6,177 at 322-23 (Oct. 1971) (free access to nursing home patients).

ments of these cases, it could be asserted that jurisdiction for a patient's cause of action is authorized by 42 U.S.C. section 1983[114] and by the Civil Rights Act of 1968.[115] 42 U.S.C. section 1983 provides for redress, including injunctive relief, for the deprivation of constitutional or statutory rights under color of state law.[116] It could be argued that a civil cause of action arises under the Civil Rights Act of 1968 when one interferes with rights of a patient to participate in and enjoy "any benefit, service, or privilege, of a program administered by the United States."[117]

Constitutional arguments could also be asserted on behalf of nursing home patients. Because the funding and regulation of nursing homes involves significant participation by the state and federal government, a strong argument can be made that the denial of the first amendment right of freedom of association is supported by state action, and as such is prohibited by the first and fourteenth amendments.[118]

Litigation by the Interested Public

Since litigation by the nursing home patients themselves is often a difficult task, concerned citizens should consider personally monitoring the quality of care provided and investigating the possibility of litigation by themselves to remedy poor conditions. Several suits instigated by legal aid groups have resulted in the judicial recognition of a constitutional right to nursing home access.[119] Moreover, it has been asserted that nursing homes are quasi-public places, and as such the patients' right of freedom of association is guaranteed by the first amendment.[120]

Concerned citizens should vigorously advocate state and federal legislative reforms which would allow greater public participation and input in the inspection and enforcement processes. They should further seek legislation which confers standing on citizens' groups, and they should encourage states to create an office which would serve as an advocate for the aged. That

114. 42 U.S.C. § 1983 (1970).

115. 18 U.S.C. § 245(b)(1)(E) (1970). For a discussion of the application of each of these sections see Brief for Plaintiff at 2, 10-12, Smith v. O'Halloran, No. 75-M-539 (D. Colo., filed May 16, 1975); NATIONAL SENIOR CITIZENS LAW CENTER, THE NURSING HOME LAW HANDBOOK 13-15 (1975); 4 Health Law Project, University of Pennsylvania Law School, Materials on Health Law 177-79 (rev. ed. 1972).

116. 42 U.S.C. § 1983 (1970).

117. 18 U.S.C. § 245(b)(1)(E) (1970).

118. NATIONAL SENIOR CITIZENS LAW CENTER, THE NURSING HOME LAW HANDBOOK 14 (1975); 4 Health Law Project, University of Pennsylvania Law School, Materials on Health Law 177-78 (rev. ed. 1972).

119. Citizens for Better Care v. Reizen, 215 N.W.2d 576, 580-81 (Mich. Civ. App. 1974); *see* 4 Health Law Project, University of Pennsylvania Law School, Materials on Health Law 168-79 (rev. ed. 1972).

120. NATIONAL SENIOR CITIZENS LAW CENTER, THE NURSING HOME LAW HANDBOOK 13-15 (1975).

office should be empowered to investigate complaints and compel enforcement of standards.[121]

More Diligent Enforcement by Agencies

Enforcement agencies are able to force compliance with federal and state standards by license revocation, removal of certification, and the imposition of fines. If these agencies do not enforce standards on their own initiative, they should be compelled to do so. Such lawsuits could be directed against governmental agencies at a variety of levels. The federal government could be sued in mandamus to compel it to enforce federal standards either by withdrawing funds from states not adequately enforcing federal standards or by decertifying noncomplying homes.[122] State governments could also be sued in mandamus and be required to enforce their licensing and health code statutes.[123]

Federal and state agencies should be encouraged to utilize their sanctions for noncompliance more extensively. Moreover, they should do so publicly so that other facilities will be induced to comply voluntarily. State legislatures or administrative agencies should enact a citation system for violations which would empower inspectors to levy fines against homes for violations and should provide that the amount of the fine be increased each day that the violation continues.[124] In addition to civil monetary penalties, the citation system should provide for injunctive relief and require the posting of citations in a public place at the offending institution. Appropriate state agencies should also maintain lists, available to the public, of all homes indicating their citation records.[125]

Further, enforcement agencies might consider initiating actions which would seek the appointment of a medical receiver for a noncomplying facility. The receiver would operate, or supervise the operation of, noncomplying nursing homes and use the revenues to bring the home into compliance with existing standards. If necessary, the receiver could authorize any structural repairs needed to achieve compliance.[126]

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121. *See* NEW YORK STATE MORELAND ACT COMM., LONG-TERM CARE REGULATION: PAST LAPSES, FUTURE PROSPECTS, A SUMMARY REPORT 40 (April 1976).

122. NATIONAL SENIOR CITIZENS LAW CENTER, THE NURSING HOME LAW HANDBOOK 16-17 (1975).

123. *Id.*

124. *Id.* at 17-18; *see* Regan, *Quality Assurance Systems in Nursing Homes*, 53 J. URBAN L. 153, 192-94 (1975).

125. NATIONAL SENIOR CITIZENS LAW CENTER, THE NURSING HOME LAW HANDBOOK 16-17 (1975); *see* Regan, *Quality Assurance Systems in Nursing Homes*, 53 J. URBAN L. 153, 192-93 (1975).

126. Cohen, *Long-Term Care: A Challenge to Concerted Legal Techniques*, 2 OHIO N.L. REV. 642, 678-79 (1975); *see* Toler v. Lula Toler Convalescing Home, 364 S.W.2d 680, 685 (Ark. 1963) (civil remedy of receivership imposed upon violation of nursing home standards).

Legislative Reforms

Reform of nursing home law should be primarily directed at establishing a uniform and coherent legislative scheme of standards and enforcement devices which would overcome the inequities and deficiencies which presently exist.[127] Efforts should be made to simplify standards and to apply them uniformly in the various states. Particular emphasis should be given to developing clear definitions and guidelines concerning patient care.

The inspection process should be strengthened through increased manpower, more frequent unannounced inspections, greater specialization and training of team members, and greater public involvement in the inspection process. Generally, all enforcement procedures should be streamlined so as to encourage their application, and additional enforcement sanctions should be imposed.[128] This would include conferring standing to initiate litigation on nursing patients and on their representatives.

Additionally, arbitration councils and ombudsman programs might be implemented.[129] These could act as complaint and information centers, with problems they could not resolve being referred to state enforcement agencies for action. Also, these councils and programs could issue reports on nursing home problems and make recommendations for their resolution.[130]

Alternatives to Nursing Care

While nursing homes are heavily relied on for the long-term health care needs of many of the nation's elderly, alternatives to institutionalization should be considered. Several state and federal programs have been established which offer homemaker and chore services for the elderly in their homes, home delivery of meals, home health care programs, and foster homes for the elderly.[131] These services enable elderly persons to live independently, in their own homes, and it is asserted that they can be provided at a substantially lower cost than institutional care.[132]

CONCLUSION

The need for high quality, long-term care facilities will undoubtedly

127. INTRODUCTORY REPORT, *supra* note 1, at 109-12.

128. NEW YORK STATE MORELAND ACT COMM., LONG-TERM CARE REGULATION: PAST LAPSES, FUTURE PROSPECTS, A SUMMARY REPORT 71-87 (April 1976).

129. In 1972, at the direction of President Nixon, HEW funded five ombudsman units in Idaho, Pennsylvania, South Carolina, Wisconsin, and Washington, D.C. The effectiveness of these programs has not yet been fully evaluated. INTRODUCTORY REPORT, *supra* note 1, at 100-01.

130. Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304, 342 (1975); *see* 4 Health Law Project, University of Pennsylvania Law School, Materials on Health Law 117-23 (rev. ed. 1972).

131. *See, e.g.*, TEX. DEP'T OF PUB. WELFARE, SOCIAL SERVICES HANDBOOK §§ 5100-5500 (Dec. 1975).

132. INTRODUCTORY REPORT, *supra* note 1, at 57-64.

continue to increase as the number of the nation's elderly does.[133] To effectively meet this demand, positive efforts by legislators, public enforcement agencies, the nursing home industry, private citizens, and the nursing home patients themselves will be required. The legislatures must remedy the inadequacies which exist in the current laws, and the public enforcement agencies must be strengthened. Private citizens and nursing home patients must be both allowed and encouraged to take a role in the legislative and enforcement processes. Finally, the nursing home industry must realize its legal and moral responsibilities. Absent these changes, existing conditions will not only continue, they will worsen.

133. *Id.* at 14-15.