P U B L I C H E A R I N G

before the

NURSING HOME STUDY COMMISSION

on

PERSONAL CARE FACILITIES FOR THE ELDERLY IN NEW JERSEY

Held:
Assembly Chamber
State House
Trenton, New Jersey
May 2, 1975

COMMISSION MEMBERS PRESENT:

Senator John J. Fay, Jr., Chairman
Senator Wayne Dumont, Jr.
Senator Anne C. Martindell
Assemblyman Joseph L. Garrubbo
Assemblyman Clifford W. Snedeker

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I N D E X

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SENATOR JOHN J. FAY, JR. (Chairman): The hearing will please come to order. On behalf of the Nursing Home Study Commission and myself, I want to welcome you to our second public hearing. For the record, the Commission was established pursuant to Senate Concurrent Resolution 15, Official Copy Reprint.

My name is John Fay. I am the Senator from Middlesex County. Senator Anne Martindell on my left from Mercer County, and on my right, Assemblyman Joseph Garrubbo from Union County are members of this Commission.

The purpose of this hearing, the second of a series dealing with these problems and possible solutions, is to inquire into the current conditions of the personal care facilities, nursing homes, and other facilities dealing with the elderly in our State, and to investigate the organization, operation, standards and policies of such facilities, their adequacy and ability to meet the social needs of our State, and the sufficiency of the State's standards for the regulation and supervision of such facilities.

As a result of this duty, and in light of the importance of the subject area which the Commission will be studying, it is the decision of the Commission to hold public hearings. That is the purpose for which we are here today. We are also planning to move this study of the Commission around the State. We intend to have public hearings in the Monmouth-Ocean area. We also intend a meeting in the Bergen-Passaic area, and other parts of the State as well. We intend to be meeting with our counterparts in Washington, Senator Moss' Committee and his staff, in the near future.

My role today, as well as that of the Commission, is simply to learn, to take statements, to hear the pros and cons of the extremely complex and important matter. We expect your cooperation and assistance in this matter, and we appreciate those who are coming forth to testify, and also those who have

been writing to us and calling us with what we feel is relevant material and information.

I would like to exercise the right of the Chair and establish the guidelines for the orderly operation of this hearing. First, we would very much appreciate it if you would limit your remarks to a maximum of thirty minutes, although the questions the Commission may ask of you following your testimony may expand that time limit. We respectfully reserve such expansion to our discretion. As you can see, there have been a number of people invited to testify here today, and I would like to provide everyone with an opportunity to be heard.

The second point concerns our hearing reporters. As you know, a transcript of these proceedings will be prepared, and will become a matter of public record; therefore, in order that your comments be recorded accurately, we ask that you speak in a clear and distinct voice. I would very much appreciate it if the reporters would indicate to me if they are experiencing any difficulty in recording the speakers.

Further, no questions should be addressed to the Commission by the witnesses. Additionally, if you should have copies of your testimony prepared, would you please give them to John Kohler, who is sitting at Assemblyman Hurley's desk, so that he can distribute copies to the Commission prior to your testimony. He will also circulate a pad for those wishing to testify at future public hearings. In conclusion, allow me on behalf of the Commission to again thank you for your cooperation. We will have as our first witness today, Stanley Van Ness, who is the Public Advocate of the State of New Jersey.

S T A N L E Y V A N N E S S: Thank you, Senator Fay. I am pleased to respond to the Committee's request that I appear here this morning to give an accounting of our Department's efforts in this vital area, and also to make some recommendations that we feel are worthy of consideration by this Committee and by other responsible agencies in this State. The testimony that I am going

to give and the report of the activities is before you in some detail. It consists of a report that was prepared jointly by the Department of the Public Advocate, and the Center for Law and Social Policy in Washington. I will not, obviously, try to read that report this morning, but I would like to highlight the report and also explain how we have become involved and the methodology that we have followed in the Department of the Public Advocate over the past 7 or 8 months.

When the Department was first established, now about 11 months ago, and as soon as we had staffed a Division of Public Interest Advocacy with some 10 lawyers, we met with the Division Director who identified areas of interest that we thought we should apply our efforts, and hopefully, our talents toward.

One of the areas of interest, and perhaps the first area that we all agreed upon, was the area dealing with senior citizen problems in the State of New Jersey. I don't think any of us would argue that the senior citizens in this State are perhaps the most burdened group of persons around. Our efforts on behalf of senior citizens has lead to participation in hearings before the Public Utility Commission on discontinuation of service. It has lead to providing proposed legislation for consideration by the Legislature in the areas of utility stamps, in the area of civil rights for patients in nursing homes, in ombudsman features for patients in nursing homes, and a host of other areas.

Early in the game we became very concerned with the felt problems of the senior citizens, dealing with the care that they were receiving or could expect to receive, should they be placed in a nursing home in this State. Mr. Waldman and Ms. Span of our staff have spent a great deal of time reviewing inspection reports of nursing homes from the Department of Health, from the Department of Health, Education and Welfare Regional Office in New York, and they have met with a number of former employees of nursing homes; they have talked with the relatives of persons in nursing homes. We have made some personal visits, and have talked to some

patients in those nursing homes, and that effort has lead us to conclude that there are indeed substantial deficiencies in the care provided for senior citizens in this State. I am not here to indict an entire industry; I am not here to try to belie the reports that have been prepared in the past that suggest New Jersey does better than most other states in this area, but rather I am here to tell you that in our judgement - and I hope considered judgement - whether New Jersey is first among the states in the union or last among the states in the union, there are still serious deficiencies in the care we are providing our senior citizens.

We hope to suggest a way that this Legislature might move in attempting to improve the service that we are providing our senior citizens. We don't offer it as a panacea, but we do think it is a proposal that is worthy of your attention. Basically what it does is attempt to strike a middle ground between the decertification or the closing of a nursing home and the toleration of conditions that should not be tolerated.

We are asking you to consider the establishment of a procedure whereby all nursing homes are rated, and the deficiencies noted are assigned a cost factor, and the State pays the nursing home only what is justified by an evaluation of what is provided to the citizen. In short, we are suggesting that the State stop paying for things that they are not getting. If we just look at Mr. Jones' report of 1972 or 1973 - the exact date escapes me - that report concluded that New Jersey nursing homes were providing better service than could be found in most states. The conclusion was also present that some 13% of the facilities surveyed were providing poor service. But we are saying that if it's 13% that are providing poor service, we should not be paying full value for poor service, and we think it is possible to evaluate each of these homes and to determine what they are in fact entitled to.

Now, we are also making suggestions relative to the

inspection procedure. The Department of Health has informed us that they are moving toward an unannounced inspection policy, and we urge them to move even more quickly toward that policy.

I recall from my days in the Air Force the fact that when the Inspector General was scheduled to be on a base things were a little bit different than they were normally. I think it's human nature to expect that people who are aware that an inspection is about to occur will clean up and shape up, and then when the inspection is over, they may very well go back to business as usual. So we think it is extremely important that the Department of Health use its teams to go around to the various nursing homes unannounced, at evening hours, on weekends, when the grossest kinds of abuses are said to occur.

We are also asking that serious attention be paid to Mr. Garrubbo's legislation that would establish an ombudsman for senior citizens in nursing homes. One of the big problems I think anyone has in trying to police this kind of activity is the fact that people who would be the complainants are people who are, by definition, most unable to help themselves, and in some instances unable to be fully articulate, and in some instances are cowed into keeping quiet about conditions that afflict them. We think it important that there be an ombudsman, whether it be in the Department of the Public Advocate or elsewhere.

I might digress for the moment to point out a concern that I have. I suggested that this report is the result of the first part of our activities on behalf of senior citizens. The intelligence that I am getting regarding the activities of the Joint Appropriations Committee suggests to me that it might be the last part of a report of our activities, and I just want to put that on the record suggesting that I think that would be disasterous, particularly in this area.

The final item that I would like to call to the Committee's attention is our need for the involvement of more citizen groups in the activities of nursing homes, the need

in recreational opportunities for the patients. In that way they can be a sort of additional inspection team of people who might, by demonstrating their concern in going to the homes, also be reasonably considered as perceptible persons who might very easily be used by the regulating agencies to provide an additional source of information about the conduct of those facilities.

That is the highlight of our report. I will repeat again that it is not my purpose to indict an industry, although there have been numerous indictments of the industry in other states. I cannot say with any certainty that we have the same kind of problems here that have been found elsewhere, but I do say with as much certainty as I can muster that we do have problems, and that we have a responsibility to get on with solving those problems. I am prepared to try and answer any questions that the Committee might choose to put to me.

SENATOR FAY: I would like to announce that Assemblyman Clifford Snedeker is now present. Are there any questions?

ASSEMBLYMAN GARRUBBO: Mr. Van Ness, I appreciate your testimony this morning, and I particularly apprectiate your comments on the bill that I have proposed creating the Division of the Ombudsman. I would like to ask you about that proposal, and get some reaction from you on whether you feel that it is well placed within your Department. As you know, the proposal that I have made and will be introduced, perhaps, as a Committee bill proposes to create the Division within your Department. Do you accept that as a resonable placement?

MR. VAN NESS: I think it is a reasonable placement, provided there are some appropriations associated with its responsibilities. We do have a Division of Citizen Complaint, which is an ombudsman for those persons who wish to complain about the State government. It seems a logical extension of that effort to provide a service for those people who wish to complain about an industry that affects the vital interests of our senior citizens.

ASSEMBLYMAN GARRUBBO: What type of staffing do you have in that particular Division?

MR. VAN NESS: I am not sure whether we are talking about before or after cuts. Right now we have a budget of 290 thousand dollars requested for the Division of Citizen Complaint. The number of people on board, I believe we have 12 professionals and clerical support. I may be off by 1 or 2 in that number.

ASSEMBLYMAN GARRUBBO: The provisions of my proposal would require that the inspections or visits be made to nursing homes as frequently as possible, but in no case less than twice annually. Have you examined these proposals in terms of what staff needs there might be in reaction to this?

MR. VAN NESS: No, I have not attempted to put a dollar sign on that bill. If you ask us to do so, we would immediately go to the drawing board and try.

ASSEMBLYMAN GARRUBBO: You referred to a rating structure for evaluating deficiencies in services provided by nursing homes. In reviewing your summary that you submitted this morning, you suggest the creation of a joint efficiency rating committee. And you suggest that this be staffed with personnel of the Department of Health, and the Department of Institutions and Agencies.

Have you established any suggestions, any guidelines, any standards upon which deficiencies should be attached to given services?

MR. VAN NESS: No, sir, I don't hold myself out as an expert on evaluating care in the sense of what it costs to provide a registered nurse or a licensed practical nurse, or what the acceptable cost for an adequate diet is, but I know there are experts in the Department that can develop that kind of information. We are suggesting that there be a stated period of time given to this joint committee to work out a measuring stick that can be used to reasonably measure the effectiveness of each institution.

There was, in fact, such a performance index established in conjuction with the study that was done in the mid-seventies. Done once, it would seem to me that it could be replicated. But what was not done is what we are suggesting can be done, and that is that that measuring stick be used to determine how much of the 50 million dollars of State money, and 50 million dollars of Federal money goes into this kind of care, and how much of it is actually being used for the value we see.

ASSEMBLYMAN GARRUBBO: Your Department obviously has done some investigating in the area of complaints and alleged abuses and so forth. Have you categorized the abuses into those most prominent and those less prominent?

MR. VAN NESS: There is attached to the full report that I have given the members of the committe this morning - and I think there will be additional copies available shortly - a listing of each of the nursing homes and the result of the most recent inspection reports. The kind of deficiencies that were found and the problem areas are noted. Now, that was current as of December, 1974. There may have been further inspections of many of those institutions, but as of December, 1974, that was the current status as compiled from the most recent inspection reports.

It demonstrates problems in the area of trained nursing care. It demonstrates problems in the area of diet, in the area of sanitation, and in the whole litany of abuses that people have found in looking at nursing home problems elsewhere. Again, it does not mean that every nursing home is in the category of providing service that is that defective in each instance.

ASSEMBLYMAN GARRUBBO: Was the area of the availability of trained nursing staff or diet the most prominent type of violation or abuse?

MR. VAN NESS: That is certainly one of those that leads the list. Social services are noted as a problem area frequently. Physician's visits certainly is noted as a problem. Those seem to lead the list, housekeeping or sanitation problems,

nursing, availability of physicians, dietary problems. That would seem to be it.

ASSEMBLYMAN GARRUBBO: I note, and I am particularly interested in the fact that you suggest that the Department of Health and the Department of Institutions and Agencies establish this rating committee in a mutual effort. It seemed to me personally, and I don't know if I reflect the opinion of the Committee as a whole, and I'm not speaking for the Committee, that at our last hearing there was some lack of a liaison between those two divisions and some overlapping of responsibility and performance. Did your investigation find that to be true?

MR. VAN NESS: I think our investigators would conclude that that is a problem. It is my understanding that Federal law requires that both Departments play a role in the regulation of this industry, and it has also been my experience over the years in government that that is always a difficult balancing out. If two agencies are responsible, sometimes it ends up that neither is responsible or things fall in the cracks between the two. I think that is a problem, and it could be addressed by some joint committee of the two departments.

ASSEMBLYMAN GARRUBBO: With regard, again, to the deficiencies that were found in the investigation of nursing homes, per se, are you aware of any findings, on the part of your investigating team, of fraud or any misrepresentations to the State relative to cost factors or staff availability, and so forth?

MR. VAN NESS: I am familiar with one complaint that came to our attention of an alleged fraud, in that -- and I believe that it was the nurse who had previously been employed at a particular nursing home who brought it to our attention, or suggested that the filing by the owner, which indicated that she was still employed, was not true, and that she had not been replaced by a registered nurse.

That matter was turned over, first, to the Department

of Institutions and Agencies. I believe it was referred from there to the Department of Health. It was ultimately referred back to us, and it is my understanding that after some period of time a penalty was assessed against the owner in the amount of $1,000. It is also my understanding that that is the first penalty that has been assessed for reasons that I suppose are most related to the cumbersome procedure that goes with the attachment of a penalty under the statute. We have addressed ourselves to that problem in our detailed report, and it is one more reason why we think it is necessary to set up another kind of vehicle that would stop payment or reduce payment unless and until the deficiencies were corrected.

ASSEMBLYMAN GARRUBBO: In the area of inspections, Mr. Van Ness, a few days ago I introduced a bill that dealt with that, which will also, I assume, become part of the Committee project. The bill requires unannounced inspections. A few problems have been pointed out to me since that time, or since my original suggestion of introduction; namely, that the Federal government requires an announced inspection at least annually. There is some dispute as to whether or not that is the fact, or whether, if there is an announcement, it must be no less than a certain number of hours notice.

MR. VAN NESS: I think there is an "if" that precedes or starts the sentence of that particular regulation. "If there is to be an announced inspection, then notice must be given within 48 hours." I read that particular language to suggest that you need not announce the inspection. But if there is any doubt on that score, I hope that it will be cleared up.

ASSEMBLYMAN GARRUBBO: Well, the one major complaint that we heard from the industry in testimony offered at our last hearing was that such unannounced inspection might disrupt the services provided because the unannounced inspection might occur at a time inconvenient to the patients and so forth and so on.

The Department of Health and the Department of Institutions and Agencies indicate that they have on occasions made unannounced inspections. Are you aware of any problems that have occurred to patients ---

MR. VAN NESS: No problems have been brought to our attention. That is not to say that an unannounced visit at some time or another might cause inconvenience, but we hope the inspection can be a complete inspection. It might be delayed while some recreational activity is taking place, but nevertheless, the inspection can be carried on in another part of the facility until the activity is concluded. We are not looking for someone to "bop" in and "bop" out. Hopefully, if they come unannounced, they will do a complete inspection, and I would think it reasonable to assume that an inspection could be done in and around the activities that were going on at the particular nursing home. If it is a problem, it has not been brought to our attention.

ASSEMBLYMAN GARRUBBO: There are just two other areas. First of all I see by a release issued yesterday that Commissioner Finley has announced the reduction of the license of one home in East Orange, the Park Avenue Nursing Home, to a provisional status.

MR. VAN NESS: We are reasonably familiar with the Park Avenue Nursing Home. We have had a number of complaints arising out of it.

SENATOR FAY: Was that one of the homes that you had complaints from?

MR. VAN NESS: That was one of the homes that we had an abundant number of complaints on, yes.

ASSEMBLYMAN GARRUBBO: I imagine you would not take issue with her?

MR. VAN NESS: I certainly have no basis to object to her action.

ASSEMBLYMAN GARRUBBO: One other area. In testimony offered last time, at the last hearing, there was a suggestion that in certain cases there have been transfers of ownership with

highly inflated leases and highly inflated mortgages between undisclosed owners, corporate entities that are perhaps owned by identical principles, all sorts of inter-corporate and inter-entity type relationships that cause to raise the cost of operation and in turn cause to raise the rate of reimbursement. Have you found any of that in New Jersey?

MR. VAN NESS: I could neither confirm or deny the existence of that kind of situation as a problem. Our evaluation thus far has been primarily directed at the kind of care patients are receiving. It is my understanding that that is an area that is being looked into by the State Investigations Commission, and it is not our purpose to duplicate things that they are doing; although, if we are permitted to continue looking at this area, as well as others, we might very well be in a position to say, "yea or nay" on that score.

ASSEMBLYMAN GARRUBBO: I just want to conclude by saying I think your Department has done a remarkable job, and you should be commended for the suggestions that it has made to the Committee, and I thank you immensely for attending this hearing.

MR. VAN NESS: I thank you for saying that, and if I didn't mention Mr. Waldman and Miss Span's name in my opening remarks, I pass the credit that you give me to them.

ASSEMBLYMAN GARRUBBO: I have spoken to them, and I know of their involvement.

SENATOR MARTINDELL: Mr. Van Ness, you have investigators going into these nursing homes. Have they found cooperation from the home? For instance, have they been able to get a look at the records which would really tell the story?

MR. VAN NESS: No. Now, we do not have the authority to conduct an inspection in the same way that the Department of Health conducts an inspection. We have gone to visit particular persons who, we had been told, could give us information. We have not examined the records independently. We have relied upon the inspection reports that were made available to us by the agencies that I identified previously.

Where we have sent someone in, we have had mixed reaction. On one occasion the person was given a tour rather than permitted to roam at large, and maybe for a very good reason , because, as I say, we do not have the authority to conduct an inspection, and we are there at the sufferance of those people who have property rights. Much of our evaluation is dependent upon an evaluation of inspections done by other persons.

SENATOR MARTINDELL: Is there any way this Committee can help you get the proper authority to look at the records?

MR. VAN NESS: Legislation, I'm sure, would give us that authority, if the Legislature would choose, yes.

SENATOR MARTINDELL: May I go back to the ombudsman question. I'm quite familiar with your Division of Citizen Complaints, and I think they do an outstanding job. I know that in the over 4,000 complaints that have come into them, I think in a period of about 7 months --

MR. VAN NESS: Since the first of July.

SENATOR MARTINDELL: Yes. They have solved the problems of over 3500, if my recollection is correct.

MR. VAN NESS: That is pretty close.

SENATOR MARTINDELL: How many of those were in connection with nursing homes?

MR. VAN NESS: I would say probably no more than 50 to 100. I don't have an accurate account of the complaints that come in. I think that the jurisdiction of that Division, at present, doesn't go to examining complaints against anything other than a State agency. So it may very well be that people have not utilized the Division's services, although they are complaining elsewhere. We have received copies of complaints about nursing homes from other State agencies who also receive them.

I can't say that it is a major source of complaint, but in terms of quality of complaints or depth of concern, I would rank it high, in connection with the other types of complaints we have had.

SENATOR MARTINDELL: The argument made in the appropriations committee when that Division was severely cut was that Legislators should really be doing that job, but of course Legislators do not have the staff, with the miserable pittance that we get for staff. We don't have lawyers; we don't have accountants; we just have -- We couldn't do it.

MR. VAN NESS: That's the argument I made, apparently unsuccessfully, before the Appropriations Committee. We are not in competition with Legislators who seek to serve their constituents, but I do think we are providing a specialized service there that most legislators could not provide for their constituents.

SENATOR MARTINDELL: There's no reason why Legislators could not work with you.

MR. VAN NESS: We hear from many Legislators who do refer complaints that were brought to their attention by their constituents. But I have to live with the judgements that the Legislature makes in its wisdom.

SENATOR MARTINDELL: I want to commend you, also, for the great job that you and your assistants have been doing.

MR. VAN NESS: Thank you very much.

ASSEMBLYMAN SNEDEKER: I'm one of the Legislators that probably uses your office as much as anyone. Do you also inspect or have you inspected any boarding home facilities?

MR. VAN NESS: Yes, we have had complaints about boarding homes. We have an ongoing inquiry into that area, and we may have some recommendations to make at a future time about that problem. It is a problem that has been brought to our attention.

ASSEMBLYMAN SNEDEKER: The State, as you know, is taking many people out of State institutions and putting them in boarding homes, those that don't need the facility of the State hospital. I think part of this Committee's concern is whether or not they are equipped to handle the individuals that will be taken out of the State hospitals.

MR. VAN NESS: I don't know whether the complaints that

we have received are sufficient to justify that question being raised. I would not draw a conclusion until we have had an opportunity to do a more thorough study. But there is, clearly, a tendency to use the boarding home as a place for former mental patients to be housed.

ASSEMBLYMAN SNEDEKER: Have you inspected any of the State hospital facilities in the State of New Jersey?

MR. VAN NESS: Not in the nursing home area. In the mental health area and in the penal area we have had some contact with State institutions, and I'm sure it comes as no surprise when I tell you that we have filed suit in connection with the operations of two of those facilities.

ASSEMBLYMAN SNEDEKER: Most of your work, then, is done on a complaint basis or based upon an inspection report that is done by another team, and then it is referred to your Department. Is this correct?

MR. VAN NESS: Well, largely it is on the complaint basis. As I tried to say at the top of my remarks, we have developed areas of interest, areas of inquiry, and we consider ourselves to be self-starters within those areas, so that we will reach out and look at a given situation even though a complaint has not come in. But, by and large, our activity is triggered by a complaint from some citizen or citizens or groups.

SENATOR FAY: I would also like to announce that Senator Wayne Dumont, another member of the Commission, is now present.

There are a few questions that I would like to direct to you. I think one point that you made bears mentioning again. We are at the point for the first time - not only in New Jersey, but in the nation - when this problem is being confronted on every possible level. And going into any area that cries for reform, there are always sensitivities, and there is always a feeling that everyone is being blamed. Unfortunately, that happens to be the case, but even more unfortunate, not

enough, in my opinion, has been done about it. Be that as it may, yes, we are going to have to step on toes, and I am sorry if I am not the most sensitive person around, but that also happens to be true. I keep repeating the fact that we are not trying to damn an industry. We are just asking the industry to recognize the fact that there are weaknesses and there are problems, and that we are all trying to work together. We are not trying to blame any one bureaucrat or any one department. I think there is enough blame to go around for everyone in this area.

Just how many nursing homes did your Department actually go into and inspect?

MR. VAN NESS: Well, we went into and inspected about a half a dozen. We reviewed the reports on 94, and these are of record in the Department of Health. Where we went, I would suppose we found the most egregious conditions that are proabably around, because those were the ones where the complaints had come from. One was mentioned earlier, and there are several others.

SENATOR FAY: Did you find complete cooperation with the Department of Health and the Department of I & A when your office called for records and called for ---

MR. VAN NESS: Well, I think not initially, but that's been a problem that is almost statewide. When people get to understand what the Department is about, we find that the cooperation increases. I think initially there was a reluctance or misunderstanding of what our proper function is, but nothing that I thought was raised to the level of obfuscation. We have been getting cooperation from the Department recently.

SENATOR FAY: Some of the recommendations we have received already at our first public hearing, and at the few informal meetings we have had, were that Dr. Finley and Mrs. Klein are going to sit down to try to clarify and strengthen their areas of responsibilities and stop this overlapping. Mr. Reilly has already told us that they are ready to recommend a night shift

and weekend coverage of our end, and the Department of Health does have a surveillance team out in the field for one of the inconsistent - or incomprehensible - positions of announced visits and inspections only during the day time.

As I said, the movement on the National level -- Senator Moss' Committee just came out the other day with 36 bills that were already presented in Albany that we have sent for, and Morris Abrams, in the last 48 hours, has made a few very strong recommendations. I would like to ask you about those.

Number one, the need for class action suits. It seems that their conclusion is that no matter how many inspectors you have in the field, no matter how many nursing home owners are trying to do their very best, the fact of the matter is that the ultimate answer might be or almost has to be a class action suit.

MR. VAN NESS: Well, that is an area that we are actively looking at at the moment, whether we should consider filing class actions on behalf of patients. In the normal procedure in this office we look to the preparation of a litigation memo, which will lay out the problem as perceived by an attorney. It will lay out the state of the law, and the possible chances of changing the law; what jurisdictional problems, if any, there might be in pursuing it, and what the probable cost in terms of commitment of time and money would be.

We are at the stage where that litigation memo has been prepared in the Department, and we will be discussing some of the peculiar problems associated with this kind of litigation in the not too distant future. So I certainly don't object to that approach, because we may use it ourselves.

SENATOR FAY: The recent bill on the Governor's desk, Senator Menza's bill, is about the bill of rights for those in mental institutions. Do you feel that the next logical step would be the same type of law for those in nursing homes or boarding homes?

MR. VAN NESS: Yes. We have a proposed piece of legislation that would establish a patient's bill of rights. We hope the Legislature will have an opportunity to consider this in the not too distant future.

SENATOR DUMONT: Stanley, there was a considerable difference of opinion as to how many nursing homes there are in New Jersey at the first public hearing. What has your Department found out?

MR. VAN NESS: We are also confused. We are relying on the Department of Health figures which, I believe, indicate there are 222, and that is different than the number the Department of Institutions and Agencies is relying on. We have not made a physical count, Senator, so we will say categorically that there are between 200 and 300 nursing homes in the State.

SENATOR FAY: One of the challenges that this Committee has found is that we must go out and count the nursing homes in the State in order to find out exactly how many there are.

SENATOR DUMONT: No further questions.

ASSEMBLYMAN GARRUBBO: We, as a part of preparation for these hearings, Mr. Van Ness, went to consult with representatives of the New York so-called Stein Commission on the Cost of Living. We found, in consultation with them and after review of our own State Commission's investigation report, that much of the problem with nursing homes may lie in the reimbursement formula, which acts, in many cases, as an inducement for the cutting of services so as to save costs, and thereby increase profits.

Did your investigation disclose areas of cuts in services? I know you referred to your staff cuts, but I am talking about cuts in services such as provision of medicines or improper medication or anything of that sort?

MR. VAN NESS: There were some deficiencies noted in that area. I guess generally I would say that almost all the deficiencies seem to have cost implications. Now whether they are

purposely instituted by an owner or not is something that I am not in the position to judge. If, for instance, they cannot get registered nurses and function with less than the number that the regulations would suggest they should, then obviously, there is a cost saving. That is really the kind of thing we are trying to get at. We are trying to say, Let's measure that. And where there is a cost savings, then let's not pay more than the value we are receiving. I guess the answer to your question is yes, generally.

ASSEMBLYMAN GARRUBBO: In moving Senator Menza's bill in the Assembly - in preparation for that and as part of the overall project - we visited one of the mental institutions in the State, and when presenting the staff with the suggestion that there was over-tranquilization going on, over-medication going on, there was not a categorical denial, but an alternative request for more funds and more staff so such a thing would not be necessary. Do you find a parallel over-tranquilization, over-medication of patients in nursing homes, or didn't your study get into that?

MR. VAN NESS: No. Our study has not gotten into it that deeply. I really couldn't say whether it is a problem or not. We would like to have an opportunity to pursue that question in the future. I could not make a statement on that.

SENATOR MARTINDELL: Stanley, did your team find any evidence of physicians charging fees for seeing patients who had not actually been seen, or laboratory tests that had been charged for and had not been given?

MR. VAN NESS: We have had complaints from relatives of patients who have alleged that that was happening. We have not been able to verify that.

SENATOR MARTINDELL: You can't verify that because you can't get to the records.

MR. VAN NESS: No; but we have heard that allegation made.

SENATOR FAY: Stanley, is this a continuing investigation or is this a final report? Are you still receiving complaints from families or from individuals?

MR. VAN NESS: We are still receiving complaints. Whether that continues or not, I suspect, is going to be decided in this body relatively soon. If we are faced with the kinds of cuts that I alluded to earlier, there will be many things that we are interested in doing that we will not be able to do. I am not saying that this is one that we would throw on the cutting room floor, but it is possible that we might have no choice in the matter.

SENATOR FAY: Well personally, and as Chairman of this Commission, I can't thank you or commend you and your staff enough. I think, as I said before, this is a break through, and nothing constructive is going to be done until these kinds of reports and these kinds of investigations are presented to us. Most certainly I, for one, feel that it is a major contribution to the solution to the problem, and I also intend to do all I can to see that your budget is maintained for reports such as this. This is not the only one that you can be commended on as far as what you and your people have been doing.

SENATOR DUMONT: Last night I spoke to a nursing home owner and operator, and his complaint was that there is a tremendous amount of paperwork they have to perform which actually wastes both Medicaid and Medicare funds. He also said, for example, that one of the regulations imposed upon them by one of the departments - perhaps I & A - is that they have to retain a consulting dietician, pay her $150 a month, and they get at the most three hour's work each month. The most she does is check menus. They don't quite see the need for all of this regulating going on. Have you run into this?

MR. VAN NESS: Well, we have heard from operators and representatives of operators that feel burdened by some of the paperwork that is required in the regulatory scheme that we have

underway. I have not heard any particular complaint about the cost associated with a dietician. On one hand, had I heard such a complaint, I might sympathize with anyone who is paying $150 for three hour's work. On the other hand, I would say that I think it is very important that there be an adequate and nutritional diet provided. Where we draw the line between that, Senator, is difficult for me to say at this time.

SENATOR DUMONT: Thank you.

SENATOR FAY: Stanley, I would also like to thank Miss Span and Mr. Waldman, and hope we will be able to sit down with them and go through this report, and we are preparing recommendations to the Departments involved, and also preparing legislation.

MR. VAN NESS: Thank you very much, Senator. I wish you great success in this endeavor, and the other one you also alluded to you might be interested in.

(Prepared statement of Mr. Van Ness appears in full beginning on page lx in the appendix.)

SENATOR FAY: Mr. Herbert Semmel, National Council of Senior Citizens and Miss Osa Jackson. Miss Jackson is a Doctoral candidate of the University of Michigan. Mr. Semmel and Miss Jackson, I want to thank you both for coming down here today. It is appreciated.

H E R B E R T S E M M E L: Senator, and Members of the Commission, we appreciate the invitation to speak here today. My name is Herbert Semmel, and I am an attorney with the Center for Law and Social Policy in Washington, and I am here representing the National Council of Senior Citizens. The Council is the largest organization of clubs for the elderly in the United States with more than three million affiliated members. It turns out that New Jersey has the largest single membership in the Association of any State in the nation.

I asked Miss Jackson to come with me today. She is now completing her thesis on gerontology at the University of

Michigan. In addition to that, she has worked as a physical therapist in nursing homes for a number of years. I felt that this Commission may not have the opportunity too often to speak to people that have actually worked in nursing homes and who have the independence to tell the Committee what they have observed there. I think you might obtain some interesting information from her. She will make a brief statement. I will reserve a little of my time, so that she can speak.

I have submitted a written statement which I would appreciate being included in the record, and which I will not read but just comment on some of the matters.

We have been working with the Office of the Public Advocate for about eight months examining the regulatory process of nursing homes. I don't think it is necessary to repeat for this committee what the U. S. Senate Committee described as the Litany of Nursing Home Abuses. I suppose if it were not fairly well accepted by the public and by the Legislature that something is amiss in the operation of nursing homes, in the care that patients are receiving, and in the cost to the State, that this Commission would not be sitting today.

I think perhaps one of the most frightening commentaries on the situation is revealed by the fact that the American Nursing Home Association recently chose to change their name to the American Health Care Association. One of the reasons they gave for that change was that they found there was a generally pejorative connotation of the term "nursing home" in our language. Now, I think "nursing home" has indeed become a dirty word in the language, and large numbers of elderly people fear entering a nursing home more than anything else. This has come about despite the fact that nationally we are spending more than one billion dollars of governmental funds - I think New Jersey's share of that is about fifty million dollars - each year; and nevertheless, the record seems to becoming increasingly clear that

many patients are simply not getting even minimally decent care, let alone the kind of totally adequate care that they are entitled to.

When we began looking into the problem of regulations, what we discovered essentially is that in New Jersey, and in most states, there was a single perceived remedy for the failure of a nursing home to abide by the minimal standards set out in both the Federal and State laws and regulations. And that single remedy was closing the home either through de-licensing or through Medicaid de-certification, which, in most cases would result in closing. Now, there are extreme cases where homes should be closed. But, by and large, it is just not an effective regulatory scheme.

For one thing, if it is done too extensively, there will be an immediate shortage of beds. There won't be any place to put people who need nursing home care. Second of all, there is a serious problem which is known as transplantation trauma. Evidence has shown that when elderly people are moved from one nursing home to another, it has disadvantaged effects upon their health. In fact, there is a very short term increase in death. It is possible to move people. It is possible to move sick patients. But it requires extensive preparation, if it is going to be done without adverse consequences. So that closing a home is not generally an effective remedy.

I think the proof of that is that very few homes are closed. In New Jersey in the past ten years only ten homes lost their licenses through proceedings started by the Health Department. And, so, we looked around and tried to devise a more flexible remedy, and we came up with the proposal which Mr. Van Ness has already outlined to you. The essence of that proposal is to remove the profit from non-compliance with the law and the regulations.

Essentially today a nursing home is paid the same rate regardless of the quality of care it delivers, regardless of whether or not it is complying with the law. Whatever the flat rate is, the

home gets it, and it gets it despite the fact that the inspection reports may show a variety of deficiencies in the home. Now, as a technical matter, there are supposed to be follow-up inspections, and the homes are supposed to show that they are correcting the deficiency. But the same kinds of deficiencies show up time after time on the inspection report. And I might add that we are talking now about the inspection reports which are made once a year in New Jersey and are pre-announced.

I think that if we had a system which you recommend of unannounced inspections we would see a higher degree of violations which are reported than we do now.

The present system of reimbursement regardless of quality of care seems to me somewhat absurd. I would like to sort of analogize it for you. If the State was going out and hiring contractors to resurface the roads, and the contractors did the job, butthe roads had cracks and holes in them, would the State pay 100% for that job and also go on continually using the same contractor to fix the road? Well, I think the answer is clearly no. But that is exactly what is happening now with nursing homes. The State contracts with the nursing home. The nursing home in the contract agrees to provide services which meet all the regulations of the State and the Federal government under the Medicaid program, and then they don't meet the regulations - which is documented by the inspection reports - but the State pays 100% of the contracts.

Now essentially what we are saying is the State should only pay for the value received, and that a system should be set up through the Joint Rating Committee which you have suggested, under which a point system would take into account the quality of care, the extent of non-compliance with the law and the regulations, and the payment to the home would be geared to that point system.

Now, in the short run, I think that point system is going to result in savings in State funds, because many homes will

be paid less than they are now. It is our hope that the savings will be short lived. The purpose of this program is to primarily get the proper care in the nursing homes, and we hope that the result of such a program would be that the nursing homes will improve the quality of care, and they will then be paid the full maximum State rate.

The cost of care, I think, is worthwhile touching on, because we have all read stories of some extraordinary profits which have been made by some nursing home operators, and there is perhaps a tendency to think that the State can simply save money by cutting the costs which are payable to nursing homes. That is simply not the case. Good care is going to cost money. I think the current New Jersey rates are about the minimum that could be paid and still produce good care. The statistics show that under the Social Security Medicare Program - which also covers nursing homes - they are paying approximately $33 a day to nursing homes in New Jersey. That is about $5.50 more than the maximum rate for skilled nursing homes in the State.

The Social Security payment is based on a reasonable cost formula. There is no fixed limit as you have under the State Medicaid Program. So that the reimbursement rate to the State, while it is higher than some states, is lower than is being paid under Medicare and it is lower than what is being paid in some other states in the northeast area.

We are not going to get good care in nursing homes very cheaply. Right now there are, of course, cases of fraud and cases of overcharge. We have seen that, and it has been documented particularly in New York, which has a different kind of reimbursement system which encourages these overcharges. But by and large I think that the extraordinary profits have been earned at the expense of the patient. That is, nursing homes have been paid by the State; they have been paid by the private patients to deliver a certain level of care, and many of them have not delivered that.

And so it is the patients who are paying for these extraordinary profits by their sufferings and by their loss of proper care.

The proposal that we have suggested, I think, comes closest to giving the State the kind of flexibility in the regulatory process which will maximize the least compliance with the laws and regulations. I should emphasize that the laws and regulations are only minimal standards, but we are not even getting that in many nursing homes not only in New Jersey but throughout the country.

If we do set up a better regulatory scheme, it is going to be absolutely dependent on a good inspection system, because any scheme requires adequate information as to what is actually going on in the nursing homes. Very simply, we think that there should be unannounced inspections and that they should be held frequently. Inspections held at least six times a year we would regard as a minimum, which is an average of once every other month.

One point I would like to emphasize, and that is that at least half of these unannounced inspections should be made after eight o'clock in the evening, between eight o'clock and midnight, because some of the worst treatment of patients, in the experience of the National Council, comes at night. The staffs are lower; the top supervisory personnel are not there; the aides would like to go to sleep as well as do their jobs; people are unnecessarily strapped into their beds; they are not assisted in reaching the bathroom, and they often are forced to lie there in their own urine until the morning comes. I think it is essential that there be nighttime visits to really find out what is going on during that crucial period.

There was a question about whether Federal regulations permit unannounced inspections. I don't think there is any question that they permit unannounced inspections. An annual announced inspection may very well be a desirable thing, because in order to complete all of the information required in the Federal forms, nursing homes do have to know in advance, once a year, when an inspection is coming, so that they can get all the information

compiled. But that has nothing to do with unannounced inspections. You could have your annually announced inspection and then you could follow that up with a series of unannounced inspections.

Another particular problem in unannounced inspections is the problem of security; that is, in keeping the unannounced inspections truly unannounced. There has been testimony before legislative committees both in New York and Conneticut which has revealed that nursing home personnel frequently know in advance when unannounced inspections are going to take place. And I think Miss Jackson will mention this point too. She had the same experience.

So the Department of Health, or whatever other agency is conducting the inspections, must take measures to make sure they are truly unannounced.

One reason, of course, that we have to rely so heavily on inspections is that nursing home patients themselves are so vulnerable to reprisals of various sorts that they simply cannot be counted on as an adequate source of reporting. It would be fine if nursing home patients themselves would write to the various State agencies and so on, but they are afraid. I think you have to realize the average age of the nursing home patient is 82 according to the recent study done by the Senate Committee on Aging. Seventy-five percent of them are women. By definition they are sick, otherwise they would not be eligible to be in a Medicaid or Medicare nursing home. A large number of them depend on personnel of the nursing homes for their most basic functions. Some must be fed; some must be helped to get out of bed; some even require help to turn over in bed. These are simply not people who can risk incurring a displeasure, even of an aide, by making complaints. There is a great mistrust that their mail might be looked at. They are afraid to make telephone calls about these matters, and the fact is that even their relatives and friends are under similar contraints.

I think it is not uncommon for relatives or friends to give substantial gratuities to aides and nurses simply to encourage them not to mistreat their relatives. So that these people are not on their own in a position to enforce their own rights, and so a good inspection system is necessary. For the same reason, I think the proposed legislation for an ombudsman is vital.

If action is going to be taken to enforce the rights of nursing home patients, it is going to have to be done by an outside agency. It is very difficult -- even the class action proposal, which I would support, requires in most cases at least one patient to come forward and act as a class representative. I think one of the advantages you have in New Jersey is that the Office of the Public Advocate may sue in its own name. If there is an ombudsman legislation, I would hope that you would include within it some material or some protection of the confidentiality so that the ombudsman would not have to reveal the names of patients from whom the ombudsman has gotten information. Even then it is not going to be easy for the ombudsman to get information directly from patients.

Another reform which we think would be very desirable is public disclosure of the conditions in nursing homes. At present the Social Security Act requires that the inspection reports of the Department of Health be made available publicly, but this is done by filing them in the Social Security Office. Now, almost no one knows that they are there. Even if someone would find this out, it is going to be a very rare person who is actually going to go down to those offices and go through all the red tape necessary to see the report. Certainly someone sick and elderly is unlikely to be physically able to do that when choosing a nursing home, and it is questionable whether their friends and relatives are going to do it. Certainly the doctors are not doing it.

We have made some inquiries of Social Security Offices to find out if anyone has ever looked at these reports, and the first thing you discover is that the average person working there

never knows that the reports are there. Those are the people working in the Social Security Office, and it is very rare that anyone actually goes in to examine the reports.

What we propose is that each nursing home be required, first of all, to post these inspection reports at the nursing home; to give copies to the patients; and particularly to give copies to all perspective patients. We would urge also a requirement in regard to any kind of promotional literature a home distributes. A nursing home should be required to give a copy of any literature to any perspective patient or any person asking for information.

We would also urge that a special program be set up to get this information into the hands of the doctors. The doctors, after all, in some cases play a major role in referring patients to nursing homes. They obviously in many cases are unaware of the conditions in the home, and through the medical societies and other media the doctor should be made aware that he can get the information about the conditions in the home at least to the extent it is revealed by the State inspection reports.

I'd like to save some time for Miss Jackson who may comment further on what we consider a crucial program for personnel training. The Senate Committee on Aging just found that 80 or 90 percent of all direct patient care comes from aides and very little comes from the actual trained nurses. These people are providing the care, and are paid very low wages, and 50% are not even high school graduates. We think there must be a training program for these people, and that it should be either run by the State directly or through the educational institutions available in the State, and adequate in-service training for non-professionals is vital.

One final point that I would like to bring to your attention, and that is the provision of home health care. I think we can all realize that many of the aged who are in nursing homes - even those who are quite sick - still would lead more meaningful, happy

lives if they were able to live in the homes of their relatives, children or their friends. A major barrier to that is the fact that our current financing system makes it very difficult to obtain the kind of home health care services needed, other than the doctor's services, outside a nursing home.

There are some provisions in the Social Security Act which allow Federal sharing. In fact, the Social Security Act requires that home health care services be made available by the State to anyone eligible for skilled nursing care, which, in New Jersey represents 40% of the total patients. The Federal law does not require that such home health services be made available for intermediate care of patients.

However, if they choose to make them available, Federal reimbursement will be provided at the Medicaid reimbursement rate, which is 50%. And I understand that the Department of Institutions and Agencies is now considering including intermediate care people in the home health services. But the entire matter is miniscule. In 1976, in fiscal '76, I believe the estimate of the Department of Institutions and Agencies is that 2300 people will be receiving home health care services as compared with 17,000 in nursing homes. The cost difference is staggering.

The State nursing home expenditures under the Medicaid program, State and Federal combined, would be in the neighborhood of $50 million. The budget, I am informed, for home health care services is $666,000. Now, I think that is far out of line, in that a major effort should be made to increase home health care services. I think the State - in addition to the fact that the people who are able to take advantage will greatly benefit - will save money to a large extent. With the cooperation of the patient's family and friends, the cost of home health services could be less than the cost of institutionalization.

I have included in my written testimony a proposal which suggests that the State can go ahead on its own with a pilot program of de-institutionalization on a voluntary basis. There

are a lot of complexities about home health care services under the Social Security Act. In order to obtain Federal reimbursement, it is necessary to have available a wide range of services and a qualified "home health service agency." Those simply do not exist in many areas of the State. It is quite complex to qualify for Federal reimbursement. However, we think that the pilot project could be instituted in which patients are given the option to go into the homes of friends and relatives.

What we have recommended is that, in order to do this without any additional cost to the State, these nursing home patients be paid a sum equal to 50% of what is now being paid to the nursing home. That 50% is precisely the State's share of the payment to the nursing home under the Medicaid program, so the cost to the State would not increase.

The people who take advantage of this would then have to contract themselves for home health care services. This would have to be carefully monitored, as a pilot program, to see that "friends or relatives" are not actually taking advantage of these people; that is, that they are not taking some aged relative into their house and not giving them care, and using, say, the $400 a month that would be paid under such a program. I think there are many, many people who would take their aged parents and relatives into the home if they had some funds available to hire a housekeeper during the day to assist when they are out at work, and if they knew there would be other services that are necessary available to them.

Now, this last proposal, I beleive, would require or might possibly require specific legislative authorization. It is not clear to me whether the Medical Assistance Act, under which the New Jersey Medicaid Program operates, would authorize this. And it perhaps would require clarifying legislation to tie it in with other income maintenance programs. But it may be possible with very simple changes to institute such a program.

Other than this last proposal, everything that I have recommended can be instituted administratively, without even the necessity for legislation. However, I think the legislature should mandate that some of these things be put into effect. They simply have not been done for a long time, and maybe now the regulatory agencies will begin to move. But such things as unannounced inspections or proper training programs or public disclosure of inspection reports, it seems to me, should appropriately be required by statute.

I would like to take one more minute just to mention a couple of points that were raised in questions with Mr. Van Ness. I think Assemblyman Garrubbo raised the question of medication. It is my understanding that the cost of medication is separately paid for under the Medicaid program. It is not included in the flat payment which is made to the nursing home. Indeed, the Senate Committee on Aging has a special report on medication which indicates that the problem is excessive medication; that too much medication is given to the patients; many of them are essentially tranquilized. They also found evidence of kickbacks and excess charges made for the medication. In some cases there were tie-ins between the nursing home and the pharmacy. I don't know if that is a problem in New Jersey.

I might also say the requirement of the consulting dietician, Senator Dumont, is found in the Federal regulations, and it is perhpas unfortunate that a dietician chooses to charge $150 for three hours of services. It would indicate the dietician regards his or her services as valuable as that of a doctor or a lawyer. But I think that there are substantial diet deficiencies in many homes; that if a dietician did a job correctly, in fact, at least nutrition - if not the tastiness of the food - would be improved.

If the Commission likes, I can answer questions now or I could let you hear from Miss Jackson first.

SENATOR FAY: We will hear from Miss Jackson.

O S A J A C K S O N: I have worked as a health professional in nursing homes, and I have been able to see various sides of the issue, the patient's side, the staff's side, the professional staff's side, as well as the nursing home administrator. I have tried to understand each side of the issue. I have also prepared a written statement which I assume you probably have a copy of, and I will try to touch on some highlights of that statement.

First of all, I feel like I am very strongly supporting the reimbursement formula proposed by Mr. Semmel. But at the same time, I feel there are certain issues which need to be looked at regarding nursing homes.

First of all, who are the patients? The patients are human beings. They are people like you and I, someone run over in a car accident, someone with a stroke. Most of them are people with a chronic disease. They are in a nursing home because they are sick, so naturally these people are not in a position to complain. I have seen a nurse go around with the inspectors, and naturally any patient, if asked by the inspector how he likes the nursing home and the food, with the head nurse standing next to them, what are they going to say? There is the fear of retaliation, and whether it is founded or not, that fear may vary from nursing home to nursing home. I think it is essential to take a good look at the enforcement legislation that is on the books.

There is legislation now which could greatly improve the lives of the patients, and these are people like you and I. We could all end up in a nursing home, and I think that is something that is very important to look at. I think that the enforcement legislation needs to focus on the quality of care, not just measure the potential for care, such as taking inventory of equipment or looking at policy statements which are written. They need to look at what is actually going on at the home that day, if the food that is delivered is warm, if the patient's water is within

his reach, is he strapped in bed so he cannot reach his call button? I think those are things that need to be looked at in addition to the written policy statements, in addition to having good administrative records, good accounting and everything else.

One thing I am strongly in favor of is unannounced inspections. I think they should be at night and for the reasons that Mr. Semmel spelled out very clearly. With announced inspections nursing homes naturally clean up, and there is nothing wrong with that. But the thing that I feel very strongly about is, what about the other 360 some days out of the year when the patients feel that there is no one really watching. If there are no linens or there are no clean gowns, who do they turn to, who can they complain to, who can the family complain to? And there really seems to be no one in many cases that they can feel free to complain to without fear of retaliation. And that is probably one reason why Mr. Van Ness gets so few complaints about nursing homes. I am not saying that all nursing homes are bad. I have seen good, quality nursing homes, and it is possible and it is realistic in today's society, but I think there are major changes in policies and enforcement of policies that need to take place.

One thing I found interesting was that in pet shops in the State of Michigan, they carry out unannounced inspections to guarantee the quality of care for animals in pet shops. I would think that the same would hold true for human beings. I think that is something we should consider.

Also, a recent HEW study done on long-term facilities announced that part of their study procedure was to use unannounced inspections, because in this way they could see the normal day-to-day operations. And that is essentially what an inspection should be looking for. At least that is what I have always understood that the taxpayer -- the inspection agency is guaranteeing that the taxpayer is getting what he has contracted to get.

I think also there is a great need to train inspectors adequately. Conneticut has one program which helps the inspectors to focus on all the varying aspects, and it is a good example of an adequate inspector training program. I think only by having trained inspectors can the inspection reports serve their functions. They provide valid information not only to the public, but to the public in the sense that they are consumers. There is a need to post the reports in the nursing home, but also I think there is a need to do what Rhode Island has recently done, that is, mandate by legislation that there be published, either monthly or bimonthly, lists of the results of the inspection reports and let the consumer see where he can buy the best nursing home care. I think it is only fair to make it available to the consumer, because after all, the consumer, the patient, that is the person we are really trying to serve. Without this information I think we are doing a great disservice to them, to bury the records or to make them accessible legislatively -- realistically we are not fooling anybody.

I think there is a great need to train nursing home aides. They are the ones who provide the basic care. They are the ones who are there twenty-four hours a day. Professionals are in facilities for a very short period of time; or, in the case of many nurses, they have paperwork, documentation which is needed, and for that reason, the aide who works with the patient needs to be prepared to deal with that patient.

I would think one step that the State could take is define exactly what is adequate nurse's aide education. I mean, what does a nurse's aide actually have to know in order to adequately take care of someone. I feel, as an educator, that you cannot take someone off the street, not really knowing what background they have, and bring them into a nursing home and have a present nurse's aide take them around and show them what to do - another nurse's aide with the same qualifications and starting point - how to change

the beds, how to transfer a patient without dropping him. These are basic skills which nursing schools teach in two, three and four years to their students. I think a basic nurse's aide deserves to be prepared to deal with the patient, because if she is prepared or he is prepared to deal with the patients, only in that way can they enjoy their jobs and do the job and deal with it psychologically. I see many nurse's aides not prepared to deal with the patients when they are only given a guided tour of the facility and turned over to take care of a cancer patient or stroke patient and they can't take it. They will vomit on the spot. They will get upset and they leave.

You cannot expect anyone to walk into a situation, especially if they are overworked, and enjoy their job and do a good job while they are at it.

Also, I think in-service education in many cases is only on paper, because there is a staff shortage as documented by the Senate reports, and in such cases the in-service director, who usually is an R. N., will naturally become the floor nurse because the basic medical care is measured more by inspection reports than the in-service training, which, at the present time is very roughly defined, if at all. I think that the State can work out various ways to develop programs such as a six-week basic course for nurse's aides, so when a nurse's aide enters a nursing home, the in-service director can work with the person and provide them with specialized training such as reality orientation, familiarity therapy and patient seminars to know who their patients are, their names-- and that's one thing that I found. In many nursing homes the patients are not known by name. I don't really understand how anyone can adequately care for someone if they don't know who their patients are or the basic problems they have to deal with.

I think only by some kind of basic course can you have an informed and sensitive staff. I think you can only have a therapeutic nursing home community if your staff is informed. I'm

not saying that you should educate nurse's aides to be Ph. D.'s or even high school graduates. What I am saying is they should be prepared to deal with what their job requires them to deal with. They should know how to put someone on a bedpan; they should know how to get someone off a bedpan. And I think without that the nursing home is not functional, and in many cases that is where it is at today.

I think a lot depends on the administrator. If an administrator is active and aggressive, it is amazing how inspiring that can be. Nurse's aides will pull together and will work hard and will try to learn if there is an incentive. But if there is not an incentive in the nursing home, then in-service education becomes very flat and meaningless. If the staff is not informed, then I think it is impossible to expect them to identify the disturbed patient, the troubled patient, the patient with mental problems, the patient who is not adjusting, because who is going to identify, who is going to point it out? If the patient cannot speak for himself - which is in many cases true - that is where you need informed, sensitive staff. Otherwise, the patient is usually ignored, labeled as senile - and as someone says, there is nothing we can do for them - or they are medicated and restrained, and they sit in quiet corners, and you walk by and you don't even notice them.

Only with an informed staff can you work out such effective, long-term treatment techniques as work therapy, and good discharge planning. I think more than anything else we have to take a look and say to ourselves, what would we want if we entered a nursing home, and I guess that's where I am coming from.

I have seen nursing homes that work, and I would like to enter a nursing home that has a bill of rights that is functional, and one in which there is an ombudsman I can turn to if I don't understand something, if I don't know what's going on; and most of all, a nursing home with a reimbursement system

which will motivate the nursing home to continue to deliver quality care more than just six days out of the year when the inspections take place. I guess that is where I am coming from.

SENATOR FAY: Thank you very much.

SENATOR DUMONT: Mr. Semmel, are you reasonably sure these things you are recommending can be done without having heavy increases in cost of Medicare and Medicaid? In this State we started what we call the mini-Medicaid program. After observing the disaster that was almost created in New York and California by starting out with Medicaid programs they could not afford, and watching them cut back, we decided we better do far less here in New Jersey if we wanted to succeed financially.

MR. SEMMEL: Well, actually, the program we suggested would not result in any cost increase at all. In fact, I think in the short run it would result in saving the state money by reducing the reimbursement paid to some of the nursing homes. Likewise, I think the initial inspection staff that would have to be hired would at least pay for itself, if not more, by discovering more violations which, again, in the short run would result in a savings.

SENATOR DUMONT: Well, what about the ombudsman system? Every proposal for an ombudsman - these proposals are more general than the one you have in mind. Every proposal that has been before this Legislature in the past several years would create such an office with an initial appropriation of a minimum of $300,000.

MR. SEMMEL: Well, I think we have -- the State is spending $50 million on nursing home care. There are 17,000 people in nursing homes. I would not think that an initial $300,000 to help insure that they get decent care would be an excessive expenditure.

SENATOR DUMONT: Well, I have a feeling that when you are talking generally about an ombudsman you are simply - especially in the case of the Legislature - asking somebody to

take over and hear the very complaints that the Legislator himself or herself ought to be hearing and doing something about.

MR. SEMMEL: I am not really sure whether members of the Legislature are really in the position to take on that kind of role. As I suggested, it is not simply hearing the complaints, because it is very difficult--I mean, it is almost impossible for a patient in a nursing home to reach you in any meaningful fashion. We need an ombudsman on staff who can go out and identify in which homes there are problems and then do what is necessary to enforce the rights of the patients who are living there. I just don't think that is really the function of a Legislator.

SENATOR DUMONT: Well, I think it is the function of a Legislator, perhaps not so much in regard to nursing homes, but certainly in regard to his or her constituents.

MR. SEMMEL: I think that is true. I think you have a constituency here that has particular problems of communicating and making its problems known.

SENATOR DUMONT: Thank you.

ASSEMBLYMAN SNEDEKER: Mr. Semmel, what other states -- have you testified in any other states with regard to nursing homes?

MR. SEMMEL: No, this is the first one. We have just finalized this program. We are now going to recommend this to a number of other states. In the course of developing it, I have talked with representatives of the Health and Welfare Departments of Conneticut and New York and Vermont.

ASSEMBLYMAN SNEDEDKER: You are familiar then with other states and other nursing homes in other states besides New Jersey and the problems that we have?

MR. SEMMEL: Yes.

ASSEMBLYMAN SNEDEDKER: I have no other questions.

SENATOR MARTINDELL: Mr. Semmel, you represent a group that supported Medicare right from the beginning, but your group now does nct feel satisfied with Medicare?

MR. SEMMEL: Well, of course, in relation to nursing homes, Medicare does not cover general nursing home treatment at all. It only covers post-hospitalization for 100 days, and beyond that the patient is then relegated to the Medicaid program.

SENATOR MARTINDELL: You have said that you have more members from New Jersey than any other state?

MR. SEMMEL: That's right.

SENATOR MARTINDELL: Have you heard complaints from your members about nursing homes?

MR. SEMMEL: Well, we have gotten complaints through clubs. The National Council of Senior Citizens is a group of about 3,000 affiliated clubs, and the clubs reflect what kind of information they are getting from the members and they send them onto the national office.

SENATOR MARTINDELL: And they are available to us?

MR. SEMMEL: Yes.

SENATOR MARTINDELL: I would like to see them. The area that I am most interested in on this Commission is the home health care and alternate care for senior citizens. Would you suggest different financing for that?

MR. SEMMEL: Well, you say different. For example, given the budgetary problems of most state governments, I would like to see more Federal financing, particularly to get you started. Basically, what you see in New Jersey is typical of most states. The amount of money spent on home health care is just a small fraction of what is spent on nursing homes, and I would like to see more money going into home health care. If it did, at least a portion of the money being spent directly on nursing homes by the Government would then go down. So I think a shift in that direction would be desirable.

SENATOR MARTINDELL: That would take Federal legislation.

MR. SEMMEL: Well, actually, it doesn't take Federal

legislation, because they have already authorized home health care services for anyone eligible for either skilled nursing facilities or intermediate care facilities.

The State of New Jersey only covers skilled nursing patients for home health care services. You could administratively cover those eligible for intermediate care facilities.

SENATOR MARTINDELL: What do you think about the bill of the Congressman from New York giving $12,000 to each family who has an elderly patient at home?

MR. SEMMEL: Well, I think that for those families, both the elderly person and the relative who want to stay together and not go into an institution, that it is more desirable for them to stay together, provided they do get adequate health care and personal care in the home. Whether it requires $12,000 a person is another question which I really couldn't comment on. But $12,000 for example is not that much different than what is being paid for nursing home care in many states. In New Jersey it would be closer to about $10,000 a year, but there are a number of states that are now paying $12,000.

SENATOR MARTINDELL: But you do feel that it would be a definite saving to the State if this program of alternate health care could be further implemented?

MR. SEMMEL: Yes, I think there would be savings because any home health care should take into account some voluntary services on the part of the family or the friends with whom the person is living; that is, you don't have to finance twenty-four hour care by someone outside the home. Now it may be that you have to pay for someone to come in during the day time when the family is away working, but they are home at night to take care of the person. I think that kind of cooperation is important.

I think what we ought to avoid is simply warehousing sick, elderly people with some relative who pays no attention to them. In that case, I think nursing homes are better. So, the

program should be voluntary on the part of the elderly person. There should be some State supervision to prevent that kind of situation.

SENATOR MARTINDELL: To go back to the earlier suggestions for inspections, in Ohio, for instance, there was some evidence or alleged evidence that some of the inspectors were receiving gifts or payoffs from the nursing homes. How would you prevent that?

MR. SEMMEL: Well, of course, this is not a problem unique to nursing home inspectors. I think one way is to distribute, that is, change the inspectors that go to a particular home, so the same inspector doesn't go back all the time. If patterns begin to develop that certain inspectors have a very low ratio of violations, whereas others find many more violations in the same home, that will give at least a starting point for an investigation and also would act as a sort of check on that kind of abuse.

SENATOR MARTINDELL: Thank you very much.

ASSEMBLYMAN GARRUBBO: Mr. Semmel, I think that you may already be aware if not I would like to advise you that the Department of Institutions and Agencies of our State already has to an extent a home health care program, and is considering its expansion, and I think that is a very worthy alternative to the institutional care that has thus far seemed to be more acceptable.

The problem, I think, seems to be one of education of the relatives, and also an offer of inducement to them to undertake a burden that they may otherwise be unwilling to undertake. As a Legislator who has prepared three bills for introduction that would, one, recite the civil rights of residents of nursing homes; two, create an office of ombudsman; and, three, provide for unannounced inspections, I find very little in your comments that I can disagree with, because they have been very complimentary to the things that I have proposed.

The thing, however, that you said that seems to be realistic or unrealistic - I'm not sure - is the frequency of visits.

You suggested that unannounced inspections take place at least every other month.

MR. SEMMEL: That's correct.

ASSEMBLYMAN GARRUBBO: I feel like a piker in that my bill provides that they would take place twice a year unless in response to a complaint. Have you determined this frequency based upon New Jersey's specific need in terms of numbers of nursing homes, numbers of problems detected, and so forth, or is this an arbitrary selection?

MR. SEMMEL: No, it's not arbitrary in the sense that it is not based on any special characteristic of New Jersey. In other words, it is not arbitrary in the sense that if you get long periods between inspections the home has quite a bit of time to relax. They may not know the exact day when an inspection is coming, but they know that within the next four months it is unlikely there will be an inspection since they were just inspected.

So I think a higher frequency for that reason alone is desirable. I was told by the Department of Health in Conneticut that they have a minimum inspection period of six times a year. Now, the inspection does not have to be as broad each time as the annual visit which is required, in which extensive information is filled out for HEW. A follow-up inspection could be done, for example, by one person, so they would not take that much time and personnel.

ASSEMBLYMAN GARRUBBO: I would think that, with the staff of the Department of Institutions and Agencies now making inspections and the Department of Health now making inspections, and by consolidating those forces, that we would certainly be able to increase the frequency of inspections. I don't know if we could reach the point of every two months or six times a year, but your suggestion is worthy of consideration.

For comment in response to Senator Dumont's question about the ombudsman program, the proposal that I have made would

call for the use to such extent as is practicable by volunteers, preferably over the age of 60, as they may better relate to the problems of nursing home residents, and that together with staff in the present departments may be able to accomodate the problem. But it is not only to visit but also to consult and counsel nursing home residents, and I think that may be part of the point that you were making.

Miss Jackson, may I ask where you were working in nursing homes?

MISS JACKSON: I worked in three nursing homes in the state of Michigan.

ASSEMBLYMAN GARRUBBO: I am asking this question for the assistance of the Committee, rather than any commentary on your testimony. We receive so much in terms of generalizations of the industry as a whole, whereas our concern is not only with that but also with the specific conditions in New Jersey. Is either of you aware of any specific problems or specific complaints, or specific violations in nursing care facilities in the State of New Jersey that corroborate the presence of other general charges?

MISS JACKSON: Well, I think--just to answer very briefly, I don't think that New Jersey is any worse off than any other state, but in the same way, from information that has been presented to me through conversations with people in this State and written information, I don't think they are any different than problems nationwide. I don't know what Mr. Semmel would comment about that.

MR. SEMMEL: I reviewed about 100 of the inspection reports that the Department of Health has filed with the Department of Health, Education and Welfare specifically on New Jersey, and there is a variety of different violations. Essentially what I reviewed was the background data for the chart which accompanied the proposal that Mr. Van Ness gave you this morning which details the various categories of violations which were found most frequently.

The Senate Committee on Aging estimated that 50% of the nursing homes in the United States were sub-standard. If New Jersey were twice as good as that, it would still mean that 25% of the nursing homes would be sub-standard.

ASSEMBLYMAN GARRUBBO: Well, perhaps the question is, where does the burden of proof lie? I am somewhat reluctant to accept condemdation based upon generalized statistics, and I am not suggesting that you are offering the condemnation of the industry in New Jersey.

You raised another point about the sufficiency of the reimbursement rate. Do you suggest that New Jersey consider an increase in its reimbursement rates to nursing homes?

MR. SEMMEL: Well, I think that adequate, decent care could be given at the current rate. If costs generally, and if health care costs in particular continue going up, then the rate will have to be increased. There is no question about that. I think at present the rate is high enough so that good care could be provided. It is certainly not too high.

I think nursing homes can make a fair profit at the current rate and still deliver good care, but they are not going to make extraordinary profits at the current rate if they deliver good care.

ASSEMBLYMAN GARRUBBO: The deficiency rating system might - if it causes a reduction in the payment to the nursing homes - result in a restoration of proper services or an elimination of deficiency. It might also, however, suggest other alternative deficiencies to offset the laws. Have you found that to be an experience in some instances?

MR. SEMMEL: I can't say I found it as an experience. I can say that we recognize it as a danger. The only way to offset that is through an adequate inspection system, and ultimately, of course, through the possibility of closing. We are not suggesting that you abolish the notion that a license be revoked. If deficiencies are discovered and the reimbursement rate is reduced, and they

are the kind of deficiencies which are serious, and if they are not corrected over a period of time, I think eventually a license revocation is appropriate. That perhaps will give us some protection against the kind of thing you have suggested.

ASSEMBLYMAN GARRUBBO: Thank you very much, Mr. Semmel.

SENATOR FAY: Mr. Semmel, as the National Council of Senior Citizens, do you have state officers and county officers? Is that the way your organization is set up?

MR. SEMMEL: There are state officers or state members of the board of governors of the organization. I would be happy to give you a list.

SENATOR FAY: What I would like to explain to both of you and to all your officers is that this is a continuing study. In January I intend to resubmit the resolution to keep this Commission alive for at least two more years. We have tried to get a permanent staff to work with us. We are at the very beginning stage at this point, and your report has been a major contribution so far. There has to be this continuous activity going on. We do want to have a direct liaison with you on the national level and most certainly with the state and local people so they can report directly to us. We need this kind of contribution. We would like to know what improvements are needed without legislation.

We intend to hold meetings around the State, so we can try to go where many of the complaints have been coming from, not only in nursing homes but also in senior citizen housing and boarding homes. We have not even scratched the surface yet. This is just the first inning of a long, long ball game. What I am trying to establish with you and your national and state organization right now is the fact that you are a major part of our study, a major area of input.

Too often we ignore the very people involved when we are making studies. It is not an academic thing as Miss Jackson pointed out. We are talking about millions of people, and thousands

of these people are citizens of ours. From your national studies have you found anything close to the ideal situation? One of you mentioned Rhode Island and Conneticut. Are there any states that are way ahead of others in implementing these improvements and reforms?

MR. SEMMEL: I don't really know if any state is particularly far ahead of the others. I think there is a variance throughout the states.

SENATOR FAY: With every third witness we run into this Federal wall, the Federal regulations and the Federal bureaucracy. Have you met with the Moss Committee yet with regard to recommendations of changes in law, administrative and formula changes?

MR. SEMMEL: We have consulted with the staff counsel. We have also discussed this with various different agencies within HEW. I think in most of these areas the Federal regulations are not a bar at all. I don't think the Federal government has done enough, but they are certainly not a bar for effective enforcement by the states.

SENATOR FAY: In regard to the training programs which you have proposed, are you talking about training programs for administrators, and staff people, and then another training program for the aides themselves?

MR. SEMMEL: We were primarily directing ourselves to training programs for the aides and orderlies, although Miss Jackson might want to say something about training programs for administrators.

MISS JACKSON: I think what we were trying to get at is the professionals who enter the nursing homes, the nursing home administrators, the physical therapists and L.P.N.'s, they all have licensing requirements. They are controlled as to the qualifications of people who enter. Whether they are adequate or not is another story. But as to the nurse's aide, at the present time, there is no true definition of what basic

information this person should have in his grasp before he enters the home, and there is really no effective mechanism because of costs and because many nurses are not trained as educators -- the resources such as libraries, speakers, films and books which are needed for a basic, short-term course, a basic introductory course on how to deal with patients as a nurse's aide is just not available at the present time.

SENATOR FAY: Have you evaluated the in-service training programs that now exist? Has there been any evaluation there?

MISS JACKSON: Well, the initial reaction there from what we were able to observe is that it depends a great deal on the nursing home administrator. If the administrator is active and concerned, then this is generated to the staff, and they will know that there is a good effort being made not to understaff. But the only thing is, even in that situation, an in-service director might not be able to teach someone how to turn a patient or how to get a patient out of bed, or how to feed a patient. Which also means she cannot deal effectively with such things as sensitizing the staff to psychological problems or special environmental kinds of things, so the nursing home can become a therapeutic community.

If she has to deal with the basics of how to get a person off the "john" and teach the aide how to do that first -- there has to be some criteria for the kinds of education a basic nurse's aide should have. Now, where the education comes from -- it could come from the nursing home. At the present time, because of the problems of cost and skill and manpower, it is not available.

SENATOR FAY: You mentioned the state of Conneticut. Did you study or observe the state of Conneticut's training program for these aides?

MISS JACKSON: Not particularly. The state of Conneticut has several other outstanding things they have done,

such as define a ratio of staff to patient, and so on and so forth. I did not take a look personally at the Conneticut program in relation to nurse's aides, but in the area of inspector training, and in other areas, they have defined criteria.

SENATOR FAY: Did you recommend in your report that community colleges and/or the local high schools and vocational schools could or should move into this area of training aides.

MISS JACKSON: Yes. I think they could adequately -- in fact there are pilot programs in various communities across the country. I know there is one program in Plymouth, Michigan, which does provide basic nurse's aide training as part of the high school vocational program. I think there are experiments in various places to provide the basic education for nurse's aides.

SENATOR FAY: Have you been in contact with the national or state nurses association to cooperate in this kind of program with regard to training and educational requirements?

MISS JACKSON: I don't think either of us has been formally in contact, but in talking to nurses in general and other professionals, I don't see where there would be a problem in that area.

SENATOR FAY: That is one thing I would like this Commission to do, contact the officers of the state nurses association and give them this particular project. They certainly should be able to come up with a training program of some sort.

I want to thank both of you again. Are there any further questions from the Commission?

SENATOR MARTINDELL: I was just looking, Mr. Semmel, at your attached deficiency report. Did you prepare that document?

MR. SEMMEL: We did prepare that report, generally.

SENATOR MARTINDELL: In New Jersey, are our reports similar to those of other states?

MR. SEMMEL: Yes. The Department of Health uses the standard form prescribed by HEW, which every state must use once a year for an annual inspection. Of course, the state is free to supplement that with additional information.

SENATOR MARTINDELL: I notice that the ratings go from four to forty-four. Four, I imagine, is very good. What is acceptable?

MR. SEMMEL: I don't think there is really any number which is the answer. A deficiency could range anywhere from a light bulb being out on an exit sign to some very serious unsanitary condition. I suspect that when you have a very serious unsanitary condition you have a lot of other deficiencies too. I don't think it would be fair to say there is any particular number of deficiencies on this kind of questionnaire which relates to quality.

SENATOR FAY: Is the life safety category a much more serious category?

MR. SEMMEL: Well, of course, life safety is related entirely to protection against fires essentially, and life safety is a peculiar thing to try to estimate. In the daily lives of the patients, life safety code has no meaning. The life safety code operates only when you have a tragedy of fire. Again, a life safety violation might be a light bulb out in an exit sign or it might be the fact that they don't have a sprinkler system. Each one of those would show up in numbers as one violation.

SENATOR FAY: Wasn't one of your recommendations that -- I would conclude that you are looking for a broader, more detailed, specific evaluation report. The evaluation reports themselves are insufficient ---

MISS JACKSON: Well, what we are asking for and what we are recommending is that the national report and the life safety code and so on and so forth is a good basic start, but there is a need to supplement that with a patient evaluation,

a practical look at what is quality of care based on its definition. And I think that is difficult to define, but HEW in the recent study that I quoted in my paper did proceed to use a patient evaluation form which tried to get at some of the basic things such as what is quality care, what is a clean patient I mean, how do you define that; is the patient clean; does he have body odor? I think in addition to looking at important things like fire safety you also have to look at what actual care you see before your eyes and document that.

SENATOR FAY: Are you saying a deficiency could be anything from a light bulb being out to a man or woman covered with bed sores? Do all these things fall into the category of a deficiency?

MR. SEMMEL: Yes, they all fall into the category of being deficient. That is why this chart you have is only minimally informative. You will have to go back and look at the reports to see what was particularly a problem in an individual home.

SENATOR FAY: Are all these reports available to the Commission and to the public?

MR. SEMMEL: Yes, they are all available. They are at the Department of Health. They are at the Social Security offices.

SENATOR MARTINDELL: They are not publicized, though.

MR. SEMMEL: They are not publicized, no.

SENATOR FAY: This has been a recommendation which has been consistent right along, the absolute need to publish reports, detailed reports, and the absolute need to post them. The individual patient and the family should have this information at hand before they sign the contract.

MISS JACKSON: But I think equally important, the information is short and concise enough that it is understandable. It is written in lay language so that it is clear what exactly is going on, and we won't wrap up a nursing home that has abuses

inside a lot of fancy words, so that nobody really understands what is going on.

SENATOR MARTINDELL: Have you any opinion on the relative care given by non-profit homes as against proprietary homes?

MR. SEMMEL: I will start out by saying that there are proprietary homes that give very good care, and there are non-profit homes that give very poor care. The National Council of Senior Citizens overall has found that the quality of care tends to be higher in non-profit homes. Although we have not advocated the total abolition of proprietary homes.

SENATOR MARTINDELL: I was told by a friend of mine who was head of the Division on Aging that it is very difficult to get community involvement in the proprietary homes, because they feel they are being exploited, and that a great protection for patients would be for friends - like pink ladies - to go in and work with the patients.

MR. SEMMEL: You do tend to find more of that in homes run by particular religions.

ASSEMBLYMAN GARRUBBO: Just one question. The deficiency rating structure, is that in effect in any state in this country?

MR. SEMMEL: That is not in effect, as far as I know, in any state. Conneticut has what they call the bonus system, which theoretically started on a base of complete compliance with the law and then gave bonus points. I have some doubts whether -- something like 90% of the nursing homes in the state were receiving the maximum rate, that is, the maximum bonus rate, which led me to believe that the system wasn't operating too well.

SENATOR FAY: I want to thank both of you very, very much. We will be in contact, and we will be meeting with you again as the year goes on.

MR. SEMMEL: Thank you. We will send you the names of the New Jersey members. I think that ongoing legislative supervision is certainly desirable.

SENATOR FAY: Thank you. We will now take a luncheon break. We will go back into session at two o'clock.

(Prepared statement of Mr. Semmel begins on page 79x in the appendix.)

(Prepared statement of Miss Jackson begins on page 97x in the appendix.)

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LUNCHEON RECESS

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Afternoon Session

SENATOR FAY: I will call the session to order. The first witness this afternoon will be Gerald Reilly, the Director of the Division of Medical Assistance and Health Services, Department of Institutions and Agencies.

G E R A L D R E I L L Y: Senator and members of the Commission: I appreciate this opportunity to come again before you to discuss nursing homes in New Jersey and our program. This time I have not prepared a written statement for presentation. I thought it would be more productive if I reflected and commented on many of the excellent ideas we heard earlier this morning, both to give you my assessment as to their merit and validity and also some analysis of where we stand with regard to these comments and recommendations.

One general comment is that much of the testimony we heard today and last time related to people who are deeply concerned about nursing homes, oftentimes from a national perspective, and quite naturally they focus on problems because otherwise they wouldn't be interested in it and be part of a movement to correct possible abuses. But I have the feeling that sometimes, and understandably so, they are not completely familiar with the system in New Jersey. Many of the things they recommend in the way of reform, I find myself almost being in a "me too" format in agreeing, although in a number of important areas, I think we have in whole or in part systems in place that meet some of the criteria and I want to talk a little bit about that. This is not to say that we don't candidly admit to problems. Any large system has problems and any large system has many opportunities for improvement and enhancement. And I think this Commission has been the crucible and fulcrum for focussing a lot of attention and helping us to move issues and ideas that perhaps otherwise would have been slower to come to pass in the

absence of such a forum.

I would like to talk a moment about inspections, which received attention from Mr. Van Ness and Mr. Semmel this morning, and the suggestion that once-a-year inspections and announced inspections were certainly not sufficient. With regard to the 17,000 patients in the Medicaid program, we have a patient assessment system wherein nurses, in some cases physicians, and in some cases social workers are visiting patients on a regular and frequent basis unannounced. The purpose of this visit is three-fold. One is the federal requirement for utilization and review to see that the patient actually requires the care being provided.

ASSEMBLYMAN GARRUBBO: Did you say unannounced?

MR. REILLY: Unannounced. The second is to assess the care being given the patient. Third is an over-all look at what is going on in a facility. This is not in any way similar to a full-scale,in-depth Health Department Licensure and Survey visit. It is for a different purpose. But because it is for a different purpose, it happens far more frequently. I think it is safe to say that each home in the State that is in the Medicaid program is visited at least monthly and most more often.

This is something I think we in New Jersey are particularly proud of because in many states the federal utilization review requirements are met simply by a paper certification where no one actually visits the patient and personally assesses the care. It is done on the basis of charts, etc. - a paper certification. We don't do that in New Jersey. Next year, we expect to do 45,000 such assessments.

The Senator stole some of my thunder by announcing yesterday before the Gerontological Association meeting that the Division was moving to a system of some off-hour visits by our physician staff and nursing staff. What we propose to do is on a random basis visit homes around the

State in evening hours and on weekends on a relatively small scale, essentially random. There may be some visits where we are having particular difficulty with a home. I think that it is our expectation that in most instances the kind of care we discover being rendered at 2:30 P.M. in the afternoon will be the same kind of care we discover being rendered at 11:00 P.M. in the evening.

What we are talking about essentially ia symbolic presence, a presence that I think would be reassuring to patients and to families, and I think that most of the long-term care facilities in the State would welcome this and be very supportive of this step. It is not going to be a full-scale inspection. It is not going to be even the normal patient assessment because there are certain things that go on during the normal business day that would not be available. It is simply a "look-see" with people who are familiar with the facility and,to use one of our physician's definition of it, that they are there to use their clinical smell and understanding of what should go on to assess what is happening. This will be starting this month.

The question of ombudsmen also came up. I think that we are very supportive, although I haven't read the Assemblyman's particular bill, for the concept of ombudsmen. I think I should point out that,among our 24 Social Workers who currently are doing work in nursing homes, one of their functions is an ombudsman role. However, they do other things. So I don't see any possible conflict with a Public Advocate-based ombudsman being supplementary to the activity of our Social Workers. The social work program is new this year and it is not fully staffed. We have 33 positions presently authorized. As I say, 24 or 25 are now filled. But we see no duplication

there. I think this is a particularly vulnerable population. There are more than enough troubles to go around and different people taking a "look-see" at different times I can't see would be harmful at all. And I don't think homes really would object very much to this notion of inspections and visits at various times. I think they would support it.

I was particularly intrigued with the proposal for a quality assessment system that we could quantify. I think this parallels very closely work we have been doing in attempting to quantify our patient assessment system, the outcome of which would be a numerical rating which one could apply to a particular nuring home. It would enable a nursing home to compare itself to others and itself to itself in prior rating periods, and it would form the basis for us to have some objectively based incentive system to encourage quality care.

I haven't read in detail the report submitted by Mr. Van Ness and worked on by Mr. Semmel. But I am somewhat cautious about the notion of negative incentives because I am concerned that the negative incentive might somehow or other be reflected in less than excellent patient care if you are going to withdraw cash-flow from a facility. I am more interested in positive incentives. Positive incentives carry a price tag and I understand that. If we are going to talk about negative incentives, I would have to see them very carefully circumscribed and controlled, for example, if you would only talk about the possibility of a negative incentive with regard to administrative salaries for the higher echelon administrators. But I think I would rather see it go in a positive direction. It has been recommended in the SCI report, for example, that we withhold funds where people have life-safety deficiencies. Our thrust has been to encourage people with life-safety deficiencies to correct

them and to reflect the cost of that correction in the rate. Negative incentives are very difficult. But I think the report has a good deal of merit and is going to be very helpful to us.

The notion of home health - this again is an area we are extremely interested in, but not as a panacea for nursing home beds and the requirement for nursing home beds. I would expect ten years from now the demand for nursing home beds will have increased by at least half, and possibly doubled. If we are very creative in the use of alternative care, we can reduce that growth somewhat; but we are certainly not going to eliminate it. The absolute need for more beds is going to continue, which makes this effort even more important.

It was, I think, very correctly pointed out that the enforcement options available to the agencies are limited. As for ourselves, we can withdraw our patients from a facility if we find we are having difficulties. That obviously is a finite option as beds are very, very scarce - very, very tight. What we have recently promulgated as policy is that, if we find a facility out of compliance with our standards, we limit admissions; we will not permit any new admissions until those deficiencies are corrected. Again this is not a perfect answer. I think some balance of intermediate steps, as called for by Mr. Van Ness and Mr. Semmel, is the direction we ought to go. To do that, we have to have some objective measures of assessing what is going on. I think, working with people in the Health Department, we could make a lot of progress here.

I appreciate the opportunity to speak a little bit out of order today. I was going to speak later and I know that we are going to have some discussion of the SCI report. I would make a few comments on the SCI report.

We have shared in detail our thoughts on the report with Executive Director Holstein and we expect to have further dialogue with him on the report.

I think that one fundamentally valid point made by the Commission is the fact that New Jersey did rely upon a schedule of imputed rentals that was developed in New York State and which New Jersey did not independently verify. I think that some other findings of fact in the report were in error and we so informed the Commission as to our belief. But I think it is really not too productive to talk about whether their arithmetic was right here or there. I think their fundamental point was a valid one and something we are moving to correct in terms of revising our imputed rental schedule.

The implication from their report that the New Jersey system was a mere image of New York's is an unfair one. And I think a careful reading of the report will find that they never said that. Some others have said they said that. I think our New Jersey system is a very, very comprehensive and sophisticated cost reimbursement system, based upon reasonable costs within administrative ceilings.

I was very happy to hear Mr. Semmel comment this morning that, as an outsider, in his view the New Jersey system was not susceptible to the kinds of overcharges that characterized the New York situation. I recognize that that is not saying our system is without fault. I think we are moving to correct some of the fault, principally this notion of an independently-developed imputed rental schedule. We think that some bench mark is needed to assess the value of real estate and I think we can do a better job of developing such a bench mark other than accepting that which was developed in another state, which has not been demonstrated to be valid or invalid, but that is reason enough for us to go into a

crash program to revise our schedule, which we are now doing. But we believe that some measure of value of real estate that can be easily administered and fairly enforced has to be developed and for that recommendation we are grateful to the SCI. We think that there is a good deal of validity to it.

I would welcome questions. I could go on for another forty minutes in commenting, but it would be more productive to have some dialogue.

SENATOR FAY: Senator Martindell.

SENATOR MARTINDELL: Mr. Semmel suggested that in order to avoid the problem of inspectors being corrupted, they could be changed, different inspectors going to different homes. Are you doing that now or do you plan to do it?

MR. REILLY: I would defer to Mrs. Hanna, our Chief Nurse, as to whether we rotate the inspection teams on a systematic basis.

MS. PATRICIA HANNA: Yes, we do. Our nursing staff, of course, is assigned around the State according to where our recipients are located. But we have not on a regular basis, say, every three months or so changed them; there are positive factors and there are negative factors in this. Of course, if you have nurses that get very familiar with the facility and with the patients, sometimes it is not the best thing to do, to move them out. But we do change them around as often as we feel is necessary.

MR. REILLY: The nature of our visits is somewhat different than a full-scale licensure and survey visit with all the formalities associated with it. I understand your point and one always has to be concerned about that when you are making decisions that do reflect reimbursements.

SENATOR MARTINDELL: Are your records of inspections open to anyone? Could I, for instance, send somebody in

to look at all your records and get copies of them?

MR. REILLY: Yes.

SENATOR MARTINDELL: At any time?

MR. REILLY: Yes. The only prohibition is that we cannot divulge a recipient's name. We have to protect the confidentiality of the recipient. The only other prohibition is: If there were some ongoing investigation relative to a home, particularly with reference to the Attorney General's Office, they have the right to seal the records. Other than that, it is all available.

Our periodic medical review reports, as was talked about this morning, are submitted to the federal government Social Security Office, etc. We do not currently have a requirement that the homes display them.

SENATOR MARTINDELL: But you could without extra legislation?

MR. REILLY: I think we could administratively. I think a legislative mandate would certainly not hurt.

SENATOR MARTINDELL: Getting to a question again we were discussing, that of alternate care, if the patients are transferred from a nursing home back to their homes or perhaps to sheltered homes, do they lose the federal funds - do they lose Medicaid?

MR. REILLY: Well, are you speaking about Mr. Semmel's proposal for a pilot program wherein we would subsidize the family?

SENATOR MARTINDELL: Yes, or hopefully, if it worked out, that it could then be expanded.

MR. REILLY: I think unless he knows of specific federal legislation that would permit that, you would run into the difficulty right now, if the State on its own did it, of whether the Social Security administration - let's say it is a SSI person - would count that as income and that income thus make the person ineligible. There are lots of snares you can trip into when you try to do things

that seem to make a lot of good sense.

SENATOR MARTINDELL: I know there are. That is what concerns me.

Thank you.

ASSEMBLYMAN GARRUBBO: I am pleasantly surprised to hear that you make as many visit and inspections as you say you do. I was unaware of them before you told me of them a little bit earlier. However, with regard to those inspections, do you think that those are the type of sufficiently in-depth inspections to evaluate health care services being provided to residents of these homes?

MR. REILLY: Not in the total sense.

ASSEMBLYMAN GARRUBBO: What more should be done?

MR. REILLY: I think if we only were doing our patient assessments, we would have a faulty system. I think in concert with an in-depth Department of Health survey and licensure visit, they do constitute a reasonably good package.

Speaking personally - I don't want to speak for the Health Department - within limitations of resources and man-power, I think it could not but be helpful if they had more frequent visits than the once-a-year basic licensure and inspection visit. But I don't know that our nurses' going in ought to do anything more when they go in. They have a fairly full mandate right now. I think they do that job fairly well. But I think different people looking from different perspectives are very helpful.

ASSEMBLYMAN GARRUBBO: You uncover, I suppose, certain deficiencies and certain shortcomings in your examinations or inspections. What do you do with those comments or complaints when you find them?

MR. REILLY: There are two kinds. There are comments and complaints that relate to our primary function of patient assessment - patient care - which are handled within the Division by discussion with the staff of the

facility face to face with our physicians and nurses to attempt to get them corrected. When a periodic medical review is done, there is a litany of the problem areas and the requirement for a plan of correction to be submitted, I believe, within two weeks. Is it two weeks? It is 30 days within which the plan of correction must be submitted, which must be reviewed, etc. But here again you run into the barriers of what options are available to an agency to really enforce.

I think there are occasions when deficiencies persist and the staff can get somewhat frustrated with it.

The other kind of problem is one which is within the Health Department's realm.

ASSEMBLYMAN GARRUBBO: You refer it to them, I suppose.

MR. REILLY: It is referred to the Department of Health.

ASSEMBLYMAN GARRUBBO: What kind of a complaint-intake mechanism does the Department of Health have, if any?

MR. REILLY: I think that would be best addressed to the Department of Health.

ASSEMBLYMAN GARRUBBO: Do you know?

MS. HANNA: They have a surveillance team. They have staff now that are assigned just to that. I am not sure how many people are assigned to this unit. But all the complaints that are sent to them, they investigate.

ASSEMBLYMAN GARRUBBO: You say they are investigated?

MS. HANNA: They are now, yes. They always did investigate, but they have not had the surveillance team for more than a few months, I believe.

ASSEMBLYMAN GARRUBBO: One of the things that concerns me is the press release that we saw issued by

the Department of Health yesterday with regard to the problem with the Park Avenue Nursing Home in East Orange. In January of 1975, certain shortcomings were detected and, here on May 1, there is finally a reaction, three and one-half months later, to that condition by a change in status of the license to a provisional status. Do you find that kind of time lag occurring there or am I misreading that press release?

MR. REILLY: I think in any administrative agency taking action, there is going to be a certain amount of time elapse. There just has to be in terms of due process, etc. I think Mrs. Hanna and Dr. Erlichman can respond to this. But it is my impression there have been complaints in the past that the department was slow to respond to complaints forwarded to it by division staff. I think that in recent months there seems to have been much more responsiveness and I suppose they are providing more resources to this problem.

ASSEMBLYMAN GARRUBBO: I don't want anyone to consider my comment to be a condemnation because I am truly asking whether or not this is a misreading on my part or whether it, in fact, took the Department of Health three and one-half months to react to their resurvey in January of '75, which implies a prior survey disclosing the same problem.

MR. REILLY: I can only respond in a general way. The Health Department could respond to that better than I as to whether that is a normal processing time or a reaction to a resurvey or not. I don't know.

MRS. HANNA: Could I speak to that? If this was - and I am not sure exactly what it was -- but if this is a post certification visit - if they went and did their survey - the facility has 90 days in which to correct the deficiencies. So if this was a post certification visit, it would not be unusual. But if it was a followup of a complaint, I would suspect that there is something

that we don't know there.

ASSEMBLYMAN GARRUBBO: That is possible.

MRS. HANNA: Very often, a facility will correct a deficiency, but maybe you go back a couple of months later and it is there again.

ASSEMBLYMAN GARRUBBO: That may be the answer. The release, however, says, "The New Jersey State Health Commissioner, Dr. Joanne Finley, announced today that the Department of Health proposes to reduce the license of the Park Avenue Nursing Home, 140 Park Avenue, East Orange, from full to provisional licensure. In a letter to Miss Marion Warner, administrator, Dr. Finley advised that the provisional licensure would go into effect on May 29 unless the nursing home requests a hearing on the matter. The provisional licensure would allow the facility three months to correct deficiencies noted," - that may be the three months you are talking about - "by inspectors from the Department of Health's facilities, survey and licensing program. In a resurvey of the nursing home on January 15, inspectors noted an absence of prior training programs; insufficient dietetic personnel on duty; improper administration, control and labelling of medication; incomplete medical records; and violations of the life-safety code. In her letter, Dr. Finley stated failure of the nursing home to correct the deficiencies by August 31 will result in a request for the issuance of an order to show cause why your license should not be revoked."

It would seem that the 90 days that you are referring to commenced as of yesterday and that this time lag between January 15 and May 1 perhaps may be an administrative problem and not a 90-day time within which to correct.

MS. HANNA: I think we would need to have more of the facts before we could comment on that.

ASSEMBLYMAN GARRUBBO: My only question of you is whether or not you find that to be representative or typical of the Department of Health's problems. It may be understaffing or what have you. Are you in a position to tell us?

MR. REILLY: I am really not equipped to comment on their problems. I know they have had a recent reorganization. It may be a function of reorganization. I don't know whether that is atypical or typical.

ASSEMBLYMAN GARRUBBO: That answers my question.

SENATOR MARTINDELL: I have been informed that upwards of 40 percent of patients in nursing homes do not need skilled nursing care and yet it is my impression that the nursing homes get more money for skilled nursing care when the patients are in on that basis. Is that a fact?

MR. REILLY: Presently, I think the figure is about 10 percent.

SENATOR MARTINDELL: Ten to 14.

MR. REILLY: Ten to 14 percent are at the SNF level, skilled nursing facility level. About 60 some percent are at the intermediate care A and the balance, whatever that comes out to, are at the intermediate care B level.

SENATOR MARTINDELL: And do they get different amounts of money?

MR. REILLY: Oh, yes. There are different administrative ceilings for the various levels. But the original statement that 40 percent ---

SENATOR MARTINDELL: Upwards of 40 percent was what I was informed.

MR. REILLY: No, I think the break is about 10 to 14 percent are in skilled right now. But a person in SCF A also needs a certain amount of skilled care, not as much; and a person in B gets skilled nursing care, but not as much. So they all need skilled nursing care to

one degree or another. It is a matter of how much.

SENATOR MARTINDELL: But you do base your costs on these variations?

MR. REILLY: Yes.

SENATOR FAY: Barring a coup d'etat, we are going to be together for at least three years working on these problems. These questions that I am going to pose to you are fundamental and basic, but they are for the record for this Commission, for the legislators and for the public.

One thing I would like to know relates to the series of quesions that Assemblyman Garrubbo just went through. Can't this be alleviated, if not done away with, this constant overlapping between the Department of Health and the Department of Institutions and Agencies? I would hope that this isn't the norm, that a place that was marked down with so many deficiencies in January is told to hurry up by August. If that is the status quo, I think we have to repudiate that right now and determine exactly what we are going to do about it. I am hoping you, Dr. Finley and Commissioner Klein will get together and do something about it. This is a major area that is screaming for attention. Our conscience demands that the inspection procedures be changed.

Are there that many legal barriers? Are there that many bureaucratic barriers that we cannot correct this in the near future for everybody's sake? I know that some of the nursing home operators have come forward and said that there is too much red tape and there are too many people coming in for this. That may be a valid complaint on one side. On the other side, we have people's mothers and fathers in an institution which was told in January it has 40 deficiencies, some of them major, involving health care, personal care,

cleanliness and medical care. Then they are told that we are hoping by the end of August this is going to be improved, not even done away with. How would you reply to that kind of a situation?

MR. REILLY: Again we are talking about the Health Department, but we can abstract that to any group of agencies.

SENATOR FAY: Right. I would like to see the Health Department and your department come together and ask: How can we improve (a) the method of inspections, (b) the number of inspections, (c) the followup of inspections, and conclusions, without waiting eight months?

MR. REILLY: I think you could probably find places totally within our own mandate where we were as slow to act as the Health Department in this particular instance. I am not finding fault with the Health Department. It is not uncommon for people within State agencies not to talk to one another, sometimes even within the same department and even within the same division.

SENATOR FAY: That is reassuring.

MR. REILLY: It is not uncommon. Really the exception to that norm is when people from various agencies work together on a team or a task force orientation. I think if ever there was an issue that begs for that kind of cooperative effort, this is such an issue. We are by law mandated to deal with various aspects of this program and I think it is incumbent upon us to work as closely with the Health Department as we can.

I honestly think that within the past couple of months there has been significant improvement and major steps in the two departments coming together and working more closely. We have monthly meetings with the representatives of the voluntary long-term facilities and the Long-Term Care Association, the so-called proprietaries.

We extended an invitation to the Health Department to participate in that meeting. They now are on a regular basis. People on our staff - and this predated me; I can't take credit for it - have begun within the last five or six months to work on a regular basis in a liaison committee with the Health Department at the staff level, not at the director level, to address the very kinds of issues you are raising.

We have a lot of information that relates to homes. The Health Department has a lot of information that feeds back and relates to our business. There has to be a sharing and commonality.

I think our present patient assessment system is essentially a good system and working. We are going to need more people as workload increases. If we are going to apply resources, maybe the resources have to be applied more in the survey and inspection area because it seems they may have difficulty having enough to go around. We are handling the caseload. We are handling the assessments. We are doing assessments on time. We will need more people as that expands.

The only thing I can say is that we need to have the commitment to talk and work together. Stanley Van Ness put it very well. He said when two agencies have responsibility for something, sometimes no one has responsibility. On the other hand, it also happens that when one agency has total responsibility, no one is accountable because there is no tension - there is no dynamic, critical review of one or the other.

SENATOR FAY: Where one department did have total responsibility, wouldn't an ombudsman or someone in an office like that be the buffer, playing the role of public defender?

MR. REILLY: I think it would be helpful. I think it is very useful to have the ombudsman both ways, in

what we do and what the Department of Health does.

SENATOR FAY: In your meetings with the Department of Health, have you been doing any thinking or have you come to a conclusion or is legislation needed relative to making the results of the inspections of either your department and/or Dr. Finley's department a public record and having them posted in the building or made a part of the brochure?

MR. REILLY: I think we could do it by regulation. I think an expression from the Legislature that they wanted it done would certainly make sure that it got done. We could do it wothout legislation though.

SENATOR FAY: As to the inspections, themselves, you have noted there are 24 Social Workers and how many RN's? 44?

MR. REILLY: Fifty-six.

SENATOR FAY: Fifty-six RN's and 24 Social Workers. Just what is your night staff and weekend staff going to be to begin with?

MR. REILLY: Well, we have described it in terms of goals at this point to the staff in charge of both the physicians and the nurses; and, that is, to do ten a month as a starter, and asking the staff who are interested and willing to do this to get into it initially.

SENATOR FAY: What I was hoping - and if I am wrong, correct me - that we were going to have a permanent night tour from 4:00 to 12:00 and a permanent weekend coverage of inspectors. Is this the case?

MR. REILLY: This would be a permanent concept.

SENATOR FAY: I am not worried about the concept; I am worried about the reality.

MR. REILLY: Right now, this staff of nurses, physicians and social workers that we have has an ongoing workload that has to be taken care of; and, for very good reasons, most of that occurs during the normal working

hours when they have access to all the materials, such as the charts and what have you, and the administrator in charge. What we are talking about doing is supplementing that with a kind of a "look-see" on a random basis in off-hours and weekends, not that we are going to attempt to conduct our normal business after eight o'clock.

SENATOR FAY: Then it won't be a normal rotating shift of nurses and/or social workers with 24-hour coverage. Is what you are telling me,that some of the people who work days will also work a few hours at night?

MR. REILLY: Yes. There will be a cadre of people who will be doing this on a regular basis. It won't be a second shift.

SENATOR FAY: It won't be a second shift?

MR. REILLY: No.

SENATOR FAY: Why couldn't it be a second shift?

MR. REILLY: I think really it is resources. We are doing the best we can, given the workland we have and the people we have to do it, to stretch and fulfill this additional responsibility of having some after-hours "look-see."

SENATOR FAY: That is not what I, personally, was looking for when we asked for nighttime inspections and full coverage of the nursing homes. But you are saying to me that you do not have the staff. That is for the record. And, if you don't have the staff, obviously you can't go into a night shift. But I, personally, was hoping that there was enough staff available to put some of those people on a rotating shift for the night coverage and for the weekend coverage.

MR. REILLY: What we are proposing does do at least some of what you want. I don't understand the difference.

SENATOR FAY: The difference is that you will not have a permanent night shift and weekend coverage if the 56 RN's and the 24 social workers are all on steady

days with some of them volunteering to go out at night on inspections. That to me is a very important distinction.

MR. REILLY: But it would be a permanent program. One can look around the State, schedule internally a month in advance where you are going to be , and say our goal this month is this number of homes to have off-hour visits. How is that different than having a cadre of people who just work a second shift, other than it wouldn't be going on every night of the month? Perhaps that is the difference.

SENATOR FAY: The difference is that the people involved, including the three witnesses this morning, all recommended and recommended strongly, as did the federal Moss Committee and the New York people, according to my understanding, permanent night and weekend, unannounced coverage.

MR. REILLY: We would have permanent night and weekend coverage. It is a question of how widespread it would be. It would be random. It would not be that every home could expect once a week somebody would be in. But even in our normal daytime assessment functions, that isn't necessarily the case. And we can do this within the resources currently available. Our option could be that we could wait until we had resources, but, at least, we can do this much with what we have.

SENATOR FAY: When you were commenting on some evidence given this morning about positive and negative incentives, I believe you felt positive incentives would be a plus, but negative incentives wouldn't be.

MR. REILLY: I said I would have serious questions about the negative and would want to read what they said in detail because negative incentives have a way of coming out in ways you didn't expect.

SENATOR FAY: Again, playing the devil's advocate, there were some things that were presented this morning,

but not in specifics. I think now we are finally getting to the point where the records are starting to flow to this Commission and we can start getting into specifics. I just want to read a few reports I have before me. One is a report on a nursing home in Wayne. I will read some of the deficiencies mentioned. We are going to have to start breaking down and being more specific about deficiencies. Where the deficiency was only dust in the hall or where it was one light bulb out, I do feel you are harassing - you are being overly harsh - on the owner and on the administrator of the nursing home. But when you get a list like this in front of you, you can hardly ignore some very, very serious deficiencies. This is dated February 10, 1975.

Medications ordered were either not given or not charted on 4 of the 10 charts reviewed. Patient with eye infection had an order for eyedrops twice a day; only one was recorded as being given. A patient had 15 miligrams of a drug ordered for sleep 8 days previous to survey date, but received it only one day, without explanation for withholding the drug. Laxatives ordered on 5 of 10 charts were not given, but enemas were ordered but not preferable. There was a shortage of 294 nursing care hours; of these, 63 were registered nurses and 231 were aide hours. A patient showed lack of care in several areas; her hair was greasy and dirty. A younger and very lucid patient reported her hair had not been washed in six months. Two patients in a four-bed room had one roll of toilet tissue for a weekend; when staff refused to give more as needed, the patients supplied their own, although shopping bags of rolls of toilet tissue were plainly visible at the patient's bedside. No one - the Nursing Director, the housekeeper or administrator - seemed aware of the problem. There was a lack of wastebaskets for bed-ridden patients. A

94-year-old man was sitting in a chair at his bedside clad only in trousers and an undershirt, and obviously shivering with cold. The search of the room for a sweater was of no avail. When it was reported, the response was that there probably were funds to supply him with one, but no concern evident about planning to have this need met. Although dietary personnel is serving food to bed patients, however, this service in the dining room was mostly by nurses aides.

We are finally at the point now where these reports are coming before us. To be able to hide under an obviously inadequate cliche like "deficiency" ---

MR. REILLY: Who did that report?

SENATOR FAY: This is signed by Dr. Finley to the nursing home, telling them, "Based upon the deficiencies noted above, you are hereby given notice the Department of Health is requesting that you show cause why your license should not be revoked. The licensee of a health care facility is afforded the opportunity for a prompt hearing on an order to show cause why your license should not be revoked under . . . (the title and section). Kindly advise the Department within 10 days. . . In the event this matter is not resolved within 10 days . . ."

I would hate to think that this is going on for 8 months before the machinery of an impotent government ever got around to correcting it. This is just one, and not the worst one that we had handed in today with Mr. Van Ness's report.

MR. REILLY: Let me describe what I would see as the best way to pick something like that up. If that home is participating in Medicaid and if there are Medicaid persons in the home, our nurses in visiting that home should pick up these kinds of things because they seem to be manifest and not hard to discover. To the extent there were Medicaid patients there, we might consider either the

cessation of future Medicaid patients or their withdrawal. The Health Department would see that this is obviously a very bad situation and would send their new special surveillance team in there immediately and within 10 days this kind of letter could come out.

That would be the kind of a juggernaut system that ought to work. I am not saying now that that is how it does work. But I would agree that that is how it ought to work.

As to deficiencies, there are lightbulbs and sprinkler systems. I think we have to put a weight, a value, on that. And that is doable. One can quantify these things and put different weights on different categories.

SENATOR FAY: Thank you very much. We will be together soon.

By the way, do you know when this surveillance team started in the Department of Health? Your new operation in the inspection area and the surveillance team in the Department of Health area - are they both working together?

MR. REILLY: Their special surveillance team?

SENATOR FAY: Yes.

MR. REILLY: Their special surveillance team just got under way.

SENATOR FAY: They just got under way?

MR. REILLY: Yes. Our obligation is to work with them across the entire spectrum.

ASSEMBLYMAN GARRUBBO: This just prompts a thought in my mind. I recognize the distinction between the services of each of the two departments. It would seem to me that the nursing home problem crosses those distinctions and has somewhat of a bit of each in them. It appears

that the bureaucracies somehow get in the way and I wonder whether or not the departments haven't considered the possibility of establishing a single unit comprised of members of both departments. Maybe I am adding a new bureaucracy; I don't know. But it would seem you refer to them in the hope they perform and react and sometimes they do and sometimes they don't.

MR. REILLY: That was a recommendation that some people have formally made, that there be a special nursing home division or department. But almost any human service issue we deal with in Institutions and Agencies and Health, the same kind of suggestion could be made. There is no perfect organizational structure. We have to rely very heavily upon both the civil and criminal justice sections of the Attorney General's Office. There is a lot of room for things to fall between the cracks there too, and we have to attempt to cooperate and work together very closely.

People in nursing homes have a relationship with the Social Security Administration; the Division of Public Welfare; our Division of Youth and Family Services, with regard to adult social services; and county welfare boards. There is a large group of people who have one piece of this action or another.

I agree with you that bureaucracies do get in the way. But I think we have to solve that by communicating. Sometimes I feel people at the working level solve a lot of problems that Directors agonize over, but we don't know it. If they are goal-oriented people, they get the job done and that is what you have to have. You have to have that kind of working-level cooperation. That is what the task forces are about.

MS. HANNA: Can I add to that that right today our social work staff is meeting with the survey teams in the Health Department to work out some of the interpretations

as far as social services go.

SENATOR FAY: Thank you very much.

Mr. James Cunningham, Executive Director of the New Jersey Association of Health Care Facilities.

J A M E S C U N N I N G H A M: Thank you, Senator. We appear here today, as Mr. Reilly, without a written statement to react to some of the comments made this morning. Following that, the people on my immediate right will make the report on our comments on the SCI report. The man immediately to my right is Mr. Edward Carr, from the firm of Howard, Listander and Berkower, accounting consultants to our Association; and next to him is Mr. Leonard Coyle, General Counsel and previous Executive Director of the Association, who will also report with Mr. Carr.

Initially, I would say we do appreciate the objective and fair tone of this hearing and of the previous one at which we testified. We have given the Committee Aide several admission statements, which you requested before. If you need more, we will be glad to get them. We have not as yet finalized our work on the report that you wanted on facilities who may have suffered bankruptcy and closings of that nature.

ASSEMBLYMAN GARRUBBO: Contracts also, Mr. Cunningham.

MR. CUNNINGHAM: That is what we have given. If you want more, you may have them. In addition, we did supply to you copies of a Patient Bill of Rights, modelled after the federal regulation,which is required to be implemented in any facility that has government patients. We have supplied it to all members and they are currently, if they haven't already, making that a part of their policies and a part of their admissions contracts, which under the federal programs, as you know, is required by law.

I would like to offer some comment on the testimony this morning of Public Advocate Stanley Van Ness. With

regard to his comments about a rating system which was received by you people, I feel that our Association would agree with that, as long as the criteria are proper, and it is objective rather than subjective in its documentation.

On the ombudsman, this has already been established in, I think, six states in the country as a pilot program type of thing. I think, at this point, even though it hasn't been before our Association in a meeting forum, that we would be favorable to that type of a program. We find from our information on the national scene that in the six states in which it has been implemented, it became as much as advocate for the facilities as it was for the patients, especially when dealing with government.

Comment was also made this morning on leases and controls on sale and resale or leases and leasebacks to people who might be related. I don't know whether or not you are aware of it, but in the current comprehensive health planning law and regulations in this State, a Certificate of Need before it is approved has to be submitted to the Department of Health. Part of the work that they do on it is a financial feasibility study. If they find that the sale price of that facility in its financial structure is not feasible and not in line with the current market, they have every right to reject that Certificate of Need. I think that would be a proper control to stop any sale or lease-back type of thing that may have happened in this State or any other state prior to adoption of the comprehensive health planning law.

With that, I will go on to the SCI report. As you may recall, on April 14th, we took exception to the SCI report on nursing homes and Medicaid, especially as it related to imputed rental. We based our objection on work developed with our accounting consultant and staff of our Association. As I said before, I have with me, Mr. Edward Carr, a CPA, who can relate to this report

and answer any questions that you might have, along with Mr. Coyle, our Counsel. Thank you.

E D W A R D C A R R: Senator Fay, we have been asked to review the State Commission of Investigation report, dated April 3rd, 1975. In examining the SCI report, where they refer to $935,000 being saved by dropping the imputed rental concept, no allowance was made for the percentage of Medicaid patients in the home versus the total patients. Our examination shows that the homes included had an average of only 60 percent Medicaid and this results in $566,000 instead of the $935,000 stated in the report.

SENATOR FAY: You are saying the savings should be five hundred some thousand instead of nine hundred?

MR. CARR: That's correct.

If the imputed rental were dropped from the program, many of the older homes would have to drop out of the nursing home business and it would result in these patients being placed in newer homes where costs are generally at the maximum. This could result in a cost to the state and federal government of $3,467,000. However, transferring these patients may be a problem. Beds are not available.

Another area that was mentioned in the SCI report was funded depreciation. It is rarely used ---

SENATOR FAY: Do you want to refer to the page of the SCI report?

MR. CUNNINGHAM: Basically, he is relating to the recommendations or possible recommendations by the SCI that start on the fourth page of the report where they talk about ---

SENATOR FAY: Arm's length leases?

MR. CUNNINGHAM: Right, and the funding depreciation appears on the next page.

MR. CARR: As I said, the concept on this funded depreciation is rarely used in commercial enterprises.

Companies look for recovery of capital expenditures over the life of the building. We have been using a 40-year life. Homes have become obsolete in the past over a 40-year period. Also, depreciation is based on historical costs and not on replacement costs. They require the moneys be held in trust accounts withdrawn only by State approval for improvement.

In the funding process, they do allow an offset of the difference between amortization and depreciation; otherwise it would be a tremendous loss of cash flow at the beginning of the mortgage payments. You would have a large cash flow from the business, that being the difference between depreciation and amortization, amortization being small at the beginning. But at the end there would be a large amortization and a small depreciation. We, therefore, disagree with this funding system.

SENATOR FAY: Any questions?

MR. CARR: I have one more statement.

SENATOR FAY: Go ahead.

MR. CARR: New Jersey has in the Medicaid program established a maximum cost to be reimbursed even if the providers' costs are greater. This differs with the Medicare program which reimburses costs applicable to Medicare patients in total.

SENATOR MARTINDELL: Your organization, Mr. Cunningham, is the New Jersey Association of Health Care?

MR. CUNNINGHAM: Yes, it is.

SENATOR MARTINDELL: I noticed in the press release that went out the Ashbrook Nursing Home. In the report we have from Van Ness's office, the Ashbrook Nursing Home had 22 deficiencies and 5 in the life-safety area. And you say the average Medicaid occupancy is 23 percent. Are the rest private patients?

MR. CUNNINGHAM: Or Medicare. The percentage

of occupancy in Medicare pretty much around the State runs about 10 percent at the most. Most facilities are lucky to have 2, 3, 4, maybe 5 Medicare; some only 1 and some none. You might occasionally find one with a higher percentage, but predominately, they are private-pay patients.

SENATOR MARTINDELL: Let's take Ashbrook Nursing Home, what is the rate that the State pays there; do you know?

MR. CUNNINGHAM: No.

MR. COYLE: Senator, we are not in a position to respond today to any specific data that may have been given to your Commission by Mr. Van Ness. We are not familiar with that data and have not had an opportunity to make any investigation in that area to provide the Commission with documentation on it.

MR. CUNNINGHAM: I wouldn't know whether they were at the maximum or whether their rate would be under the maximum without looking at the Medicaid schedule of facilities and their rates.

SENATOR MARTINDELL: But you can find out?

MR. COYLE: Yes, we can ascertain that, Senator.

SENATOR MARTINDELL: The private patients on the whole pay much more, do they not?

MR. CUNNINGHAM: Not much more. Under Medicare and Medicaid, the government is not permitted to reimburse facilities more than their semi-private rate. Normally, the semi-private rate would be either the same or not much more. A strictly private rate for a private room would be more.

One comment though on deficiencies: The Ashbrook Nursing Home is not a member of our organization; however, that is not to say we would not accept them as a member. I have been in the facility on a number of occasions. It is a newer type of facility. The number of deficiencies

that you are quoting, unless some of them are minor types of things, easily and readily correctable, surprises me.

SENATOR FAY: How do you determine whether to accept a member or not?

MR. CUNNINGHAM: They file an application. Naturally, we will accept an application from anyone who would want to submit one. Upon receipt of that, we discuss the facility with the Department of Health, as to its record with them, whether there are problems and what the situation is. We then also discuss the facility with Medicaid, as to any problems that they may be having it. They are required to give references on the application. One of the references must be a member. So we would check with the references and maybe with some of our people in the area. If we find that all of these reports are not favorable, we would send our peer review committee into the facility and we would pick people on our peer review committee not from the area in which that facility is located, because they might tend, since they are competitors and may be friends, not to be as objective as our members from out of the area. All of these reports are put together and a recommendation made to our Executive Board and a vote is then taken to accept or reject.

SENATOR FAY: Are your yearly dues determined on the number of beds they have?

MR. CUNNINGHAM: Yes, they are.

SENATOR MARTINDELL: I have the answer to my own question. The Ashbrook Nursing Home is paid at the rate of -- well, from $23 to $27 a day.

MR. CUNNINGHAM: That is by level of care. The $23 is probably level B. The maximum under skilled is $27.60.

SENATOR MARTINDELL: Then they are close to it.

MR. CUNNINGHAM: Then they are not quite up to the maximum.

SENATOR MARTINDELL: What are your standards for admission? Do they have to meet a certain standard? You said they didn't belong to your Association.

MR. CUNNINGHAM: The Ashbrook?

SENATOR MARTINDELL: Yes.

MR. CUNNINGHAM: Right. They have never applied to my knowledge.

SENATOR MARTINDELL: But you do have standards for admission?

MR. CUNNINGHAM: Yes, we have a code of ethics. And, as I said to Senator Fay, we discuss them with the Department of Health, with Medicaid, with the people they give as references and with our people in the area. If all of these are not favorable, then we send a couple of our peer review committee members in to take a look at the facility and file a report back with us.

SENATOR MARTINDELL: Why would the older homes drop out?

MR. CUNNINGHAM: As a result of this imputed rental reduction? Is that what you are referring to?

SENATOR MARTINDELL: Yes.

MR. CUNNINGHAM: They could - and that in itself is an assumption - because of financial reasons either withdraw from the program or possibly go out of business. With the shortage of beds in the State, if beds could be found, they would undoubtedly be at a higher rate because normally in the older type of facility, even though it could be giving very good personalized care, its reimbursement rate would be much lower than the newer-type facilities because of mortgage and other carrying charges.

ASSEMBLYMAN GARRUBBO: Are you suggesting there would be a loss of nursing home facilities and a loss of beds if we were to reduce the imputed rental formula?

MR. CUNNINGHAM: No, we are saying that that could be a result, which would be much more expensive than the

savings that could be realized by the abrogation of that imputed rental factor. That factor was basically utilized initially by Medicaid in order to properly compensate a facility -- we say properly. The imputed rental, I assume you know, is based on the date the building was constructed, not the date even that it became a nursing home and not the current date. It is the date it was constructed. But that was designed to stop just what happened in New York - sales and lease-backs, related leases that weren't brought forth - feeling that if they were compensated to some degree, you wouldn't get that kind of abuse that they are reporting in New York.

ASSEMBLYMAN GARRUBBO: But in New Jersey, we just took that and added 10 percent flat to it.

MR.CUNNINGHAM: That, we say, is not accurate.

ASSEMBLYMAN GARRUBBO: It is not accurate?

MR. CUNNINGHAM: No.

SENATOR MARTINDELL: What is accurate?

MR.CUNNINGHAM: That would be accurate in the imputed rental area if you took rural New York and compared it with urban New Jersey. One of the examples we used in our press release, in utilizing that theory, was Bergen County and its counterpart Rockland County in New York. Rockland County is on the urban list in New York. New York has an imputed rental for urban areas and one for rural areas up-state. New Jersey has one for urban areas and for rural areas. If you compare New Jersey's urban areas to New York's rural areas, that would be so.

ASSEMBLYMAN GARRUBBO: Isn't that what it does? Isn't the imputed rental based upon the New York rural rate?

MR.CUNNINGHAM: Yes, it is, when you assume it in that manner.

ASSEMBLYMAN GARRUBBO: Aren't those comparable construction costs?

MR.CUNNINGHAM: Urban New Jersey to rural New York? I would say, no, especially when you look at Rockland County and you look at Bergen County. You are saying that Bergen County should be compared with rural New York instead of urban New York or even Rockland County right across from it. That's the point that we make. In comparing urban New Jersey and urban New York, you will find that the New Jersey schedule is less than New York's. But if you compare urban New Jersey with rural New York, yes, the New Jersey schedule is 10 percent higher.

ASSEMBLYMAN GARRUBBO: I disagree with your basic premise. I think that New Jersey based its urban schedule upon New York's rural schedule. I think that is more the approach that was taken and not vice versa.

MR. CUNNINGHAM:That may have been. We are not in agreement with that being done.

ASSEMBLYMAN GARRUBBO: But it is a different comparison than the one you were making a moment ago. If you compare New Jersey's urban construction costs to New York's rural construction costs, I think you are going to find a far greater comparison than if you do vice versa.

MR.CUNNINGHAM: To some degree, if you are going to compare Cape May County ---

ASSEMBLYMAN GARRUBBO: Doesn't that somewhat undermine your argument?

MR. CARR: New Jersey also has an urban and a rural table. Where New Jersey's urban table exists, it has been drafted from the rural New York table.

ASSEMBLYMAN GARRUBBO: Right.

MR. CARR: And New Jersey goes on and further reduces its imputed rentals for the rural areas and the rural counties.

ASSEMBLYMAN GARRUBBO: And you find that to be an improper way to proceed, to compare urban New Jersey's to rural New York's construction costs? Do you find those two incomparable?

MR. CARR: No, we are not saying they are incomparable.

But the SCI has suggested that they further reduce the imputed rental schedule for New Jersey.

ASSEMBLYMAN GARRUBBO: In rural areas?

MR. CARR: You mean, totally eliminate the 10 percent addition that was placed on originally.

MR. CUNNINGHAM: They are suggesting either possibly the abrogation of the entire imputed rental and going strictly to cost or eliminating the 10 percent, right.

ASSEMBLYMAN GARRUBBO: I read the report that suggests the elimination of the 10 percent as at least a first step. But I don't follow your argument.

MR. COYLE: I think, Assemblyman Garrubbo, that our approach to the problem as we analyze it perhaps may be looked at in a different perspective. Our position is that the comparison made by the SCI in its report to the New York situation is not a fair comparison nor is it an accurate comparison.

ASSEMBLYMAN GARRUBBO: Let me back up a minute. Let me ask you this question: Are you taking the position that the present imputed rental formula utilized by the State of New Jersey is or is not a fair one?

MR. COYLE: Let me say this, Mr. Assemblyman: I think, basically, it is a fair schedule. Certainly it has not been found to be an invalid schedule. The only issue raised concerning the schedule that is presently in use is that it was adopted from New York, patterned after New York, and the SCI was unable to get any validating documentation relating to the use of that table.

ASSEMBLYMAN GARRUBBO: Do you think it was right or wrong for New Jersey to adopt the imputed rental formula that New York was using, without further inquiry into the basis of that formula?

MR. COYLE: Well, I can't vouch for the extent of the inquiry that was made.

ASSEMBLYMAN GARRUBBO: Forget about that part of it. Do you think it was proper or improper for New Jersey to have adopted the New York formula as it did?

MR. COYLE: The formula that was adopted here in New Jersey, of course, is not identical to that in New York; it has a far lower base year in which reimbursement is recognized for historical costs. It goes back to 1934.

ASSEMBLYMAN GARRUBBO: Without telling me the differences, do you think it was proper or improper for New Jersey to have taken New York's formula as it did?

MR. COYLE: I think in the context of the program, Assemblyman Garrubbo, you have to understand that when this program was beginning, there were problems that perhaps may not exist today.

ASSEMBLYMAN GARRUBBO: You are telling me why it may not have been proper.

MR. COYLE: No, I am not saying why it may not have been proper; I am trying to state why it had a proper proper validity. In the context in which the problems arose at the time, I think ---

ASSEMBLYMAN GARRUBBO: Mr. Coyle, I am not asking you to justify it or attack it. All I want to know is if you agree that it was a proper foundation.

MR. COYLE: I feel it was a proper method of reimbursement.

ASSEMBLYMAN GARRUBBO: All right. So you start off with a basic disagreement in premise with the SCI conclusion; am I correct?

MR. COYLE: The SCI merely adopts a different philosophical approach toward reimbursement when it comes to a fixed, overhead-cost reimbursement item. The question is: What is the most equitable method of reimbursement to our facilities for this type of cost? The problems that were considered at the time when this formula was adopted, I think were far greater than those which SCI probably dealt with when they made a critical analysis of the current system of reimbursement. And the reasons behind the

philosophy which predominated in adopting that kind of formula were certainly different reasons than someone looking at it from a purely critical position today would come up with. For instance, one of the compelling reasons why the imputed rental theory was adopted and found feasible for New Jersey after they looked at New York, as I understand it, was to encourage many of the smaller nursing homes who would not have participated, because they could not have found it financially feasible to participate in the program, to come into the program. At the time, a substantial minority of the beds that were available to provide for the Medicaid patients was in the smaller, older facilities that had very low amortization costs and very low overhead costs.

ASSEMBLYMAN GARRUBBO: That was New York's basis for establishing the formula, correct?

MR. COYLE: Yes, and I think it was a valid basis.

ASSEMBLYMAN GARRUBBO: Was that what the New Jersey officials proceeded on? Let me refer you to page 24 of the SCI report where they say in paragraph 2, "New Jersey officials erroneously concluded that the purpose of imputed rentals was to prevent sale and lease-back. The actual reason was that New York,knowingly,devised a system which would be attractive to owners of older nursing homes so that as many homes as possible would be persuaded to participate in the program." Do you agree with the assertion that New Jersey officials erroneously came to the conclusion that the purpose of the imputed rental formula was to prevent sale and lease-back?

MR. COYLE: I can't speak on whether they came to a conclusion erroneously or not, Assemblyman Garrubbo. I think that would be better addressed to those who made that decision.

ASSEMBLYMAN GARRUBBO: Doesn't that really go to the

heart of the problem though? Aren't we here trying to evaluate, perhaps retrospectively and perhaps a few years late, the reliability of the approach taken by the New Jersey authors of this whole program?

MR. COYLE: I think if you look at it from the viewpoint, "are you questioning its validity today, its continued validity, and whether it should continue today," that is one issue. But if you are looking at it as to whether it was valid and grounded upon valid grounds when it was adopted, I think that is a second issue. That is an entirely different issue.

ASSEMBLYMAN GARRUBBO: I can appreciate your verbosity because we are both lawyers and I know that lawyers answer questions with lengthy answers. But my question to you is: Don't you think it is important - and I think you can answer this, yes or no - don't you think it is our purpose here to examine the validity of the approach taken by the founders of this program?

MR. COYLE: Sure. I don't see any reason why that shouldn't be done.

ASSEMBLYMAN GARRUBBO: In doing that, it is necessary that we evaluate the assumptions upon which those people proceeded relative to the New York formula which they adopted, right?

MR. COYLE: Yes.

ASSEMBLYMAN GARRUBBO: So then it is important to determine whether or not the SCI is right, that the New Jersey officials erroneously concluded the basis of the New York formula.

MR. COYLE: I imagine you would want to make that conclusion, Mr. Garrubbo.

ASSEMBLYMAN GARRUBBO: You don't find it important?

MR. COYLE: I don't feel that it was erroneous at all. This is a conclusion reached by SCI and I don't agree with their conclusions.

MR. CUNNINGHAM: When you say "erroneously," I don't know that the Medicaid officials made that conclusion with the thinking that that was New York's reason. I think that that was a conclusion the New Jersey people made themselves, and not necessarily the reasoning that New York used when they implemented it.

ASSEMBLYMAN GARRUBBO: I have no other questions.

SENATOR FAY: I just have a few, which are more aimed at the accountant. I flunked sixth grade arithmetic too, so I am in awe of you. According to your press release, "Imputed rental is a concept in which Medicaid applies a value to nursing home property that may have lower than normal real estate carrying charge. The SCI said actual carrying charges should be used for the 59 nursing homes. Thus it calculated savings of $931,495." Now you are saying that it wouldn't be a saving of $931,000; it would only be a saving of $500,000?

MR. CARR: That's correct.

SENATOR FAY: Is there some gap in here that it is not a million dollars off - it's only a half million dollars off?

SENATOR MARTINDELL: Isn't that partly federal funds? Doesn't that account for half of it?

MR. CARR: Federal funds do count for half of it.

SENATOR MARTINDELL: That's what I thought.

SENATOR FAY: Your accountant and your organization are saying that the $931,000 - I am rounding the figures off -- instead of a million-dollar savings, it would only be a half-million-dollar savings. This is off by a half a million, not by a million.

MR. CARR: That's correct. The reason for it is because the mix in the nursing homes is not 100 percent Medicaid, but only 60 percent Medicaid. Therefore, in the reimbursement formula only 60 percent of the people

are affected.

SENATOR FAY: Correct me if I am wrong. I keep saying that we didn't take the $20 from you; we only took the $10 from you. So what are you getting angry about?

MR. COYLE: I don't understand the nature of your statement, Senator.

SENATOR FAY: For example, the SCI says, with the imputed rental formula that the State of New Jersey was using, there would have been a $931,000 saving. You are saying that's wrong, that there would only be a half-million-dollar saving. Wouldn't that be enough to recommend it?

MR. COYLE: --- providing that you in fact have a savings, Senator. You are not talking about a bottom-line figure when you are talking $500,000. We take the position if you are going to save $500,000 - and that is your bottom-line figure from the SCI report - and you do in fact put that provision into effect, it is going to cost the State of New Jersey an additional three and a half million dollars over and above the $500,000 you are going to save.

SENATOR FAY: I was coming to the conclusion that their accountants were saying that you definitely would have saved $931,000 ---

MR. COYLE: And they were in error.

SENATOR FAY: --- and you were saying they would save $500,000.

MR. COYLE: We say the maximum they could have saved was in the range of $500,000.

SENATOR FAY: Therefore, that money could have been saved.

MR. COYLE: As a top-line figure, but not as a bottom-line figure. If they try to save it in the manner in which they recommended and if they take the bottom-line figure, they are going to lose and it is going to

cost the State an additional $3 million.

SENATOR FAY: It is going to cost $3 million?

MR. COYLE: That's correct.

SENATOR FAY: You don't say that in your press release.

MR. COYLE: Sure.

SENATOR FAY: So you are saying really that you are not going to save $900,000 - you are going to lose three million?

MR. COYLE: You are not going to lose it; you are going to spend three million dollars more.

SENATOR FAY: The State would spend three million dollars more instead of saving ---

MR. COYLE: --- $500,000.

SENATOR FAY: The SCI report says you would save one million; you are saying it would cost three million dollars more to the State.

MR. COYLE: That's correct - the bottom-line figure.

MR. CUNNINGHAM: As an aside, Senator, we owe an apology to the Commission and to the SCI. If you look on the first page, our very first SCI calculation was imputed rental and carrying cost and you will find we made a second-grade error in subtraction.

ASSEMBLYMAN GARRUBBO: Nobody is perfect, Mr. Cunningham.

SENATOR FAY: I have just a few suggestions for you and your Executive Board and membership. I would like to have you, your Executive Board and your membership consider the recommendations that were made by the National Council for Senior Citizens and presented by Mr. Semmel, particularly in the area of visits and inspections. Then also, I think we all have to come together and do something about the training of personnel, especially the aides.

I would like to hear your views on my own recommendation for the posting of the monthly reports (a) in the building, (b) to the family of the patients, and (c) in your advertising brochures.

MR. COYLE: We will submit written comments to the Commission on the recommendations made by the previous witnesses.

MR. CUNNINGHAM: I can make one comment on education, Senator. In some areas of the State, there are some very good two-year training programs in the high schools for aides. They are not permitted out into the facilities for their on-the-job training part of their program until the second year. We find there is a program also at the Mercer County Community College, and have advertised this to our people in our News Letter. It is probably not enough throughout the State, but in some areas they do a very good job on this and our people find that the individuals supplied to them through those kinds of training programs are good and properly-trained people.

SENATOR FAY: I intend to call before our Commission a few people from the State Nurses Association and also from the Department of Education, if we can get them out of Newark within the next six months, to sit down with us and discuss these curriculum recommendations in high schools, vocational schools and in the Community Colleges. By the way, for the record, the State Nurses Association has contacted this Commission and has offered its help and support with regard to bringing training into the programs for everybody involved.

MR. CUNNINGHAM: We have done quite a bit over the last couple of years in education, really spurred by a questionnaire we sent to all our members at one time, asking: What do you want your Association to do for you? Education came out far above anything else. We have done a lot of

work with the Jersey City State College - and you might be interested in talking to them - and with Rutgers, with whom we have worked. We have done some work with the Thomas Edison College, with which I am sure you are familiar. We have worked with the Office on Aging which has even supplied us some funding for training in the area of reality orientation and remotivation. We have run sessions in the State on their funding, along with the Non-Profit Association. We have trained people to go into the facilities and do the same. We have worked with HEW in training activities. We recognize the value and the need in the educational area.

SENATOR FAY: Are most of these people because of their lack of training or education or a combination of the two at the minimum of the wage scale? What are the wages for a Nurses Aide in the State?

MR.CUNNINGHAM: I would say that you would find in New Jersey, they are probably above the minimum wage. And, as you know, the minimum wage in New Jersey is above the federal. I think the only place you might find them around the minimum is at the starting salary and then only probably for a two- or three-months' period of time in a strictly rural area. Other than that, you will find ---

SENATOR FAY: What would you say is the average, taking rural and urban? Would it be around $2 to $2.50 an hour?

MR.CUNNINGHAM: Some of them are over $3 an hour.

MR. COYLE: I might add, Senator, that the recent demand made by unions who have been very active in this field lately is for a minimum salary for Nurses Aides, unskilled personnel, of $10,000 in three years.

SENATOR FAY: What percentage of Nurses Aides belong to a union?

MR. COYLE: I don't know if we have those figures

available, Senator, as to how many employees may be unionized.

MR. CUNNINGHAM: I would only guesstimate it and would probably say about 35 percent.

SENATOR FAY: Thank you very much. We appreciate it.

MR. COYLE: Thank you, Senator.

SENATOR FAY: The gentlemen from the SCI.

M I C H A E L S I A V A G E: Mr. Chairman, my name is Michael Siavage and I am Counsel to the State Commission of Investigation. The Commissioners have asked me to appear today on behalf of them. Also sitting with me is Mr. Jules Cayson, who is our Chief Accountant.

I have a short statement that I would like to read into the record before I go any further.

Members of the Commission:

I wish, at the outset, to thank the members of this Commission on behalf of the Commissioners of the S.C.I. for the opportunity to appear before you today to discuss the Commission's "Interim Report on New Jersey's System of Reimbursement of Rent and Carrying Costs to Nursing Homes Participating in the Medicaid Program." The Commissioners are of the opinion that aggressive study and open dialogue such as this hearing are prerequisities to a meaningful restructuring of certain portions of New Jersey's Medicaid Program. It is just this sort of free interchange of ideas which should have taken place five years ago when the Medicaid program was being instituted. The fact that it did not is one of the reasons why we are here today. It is the sincere hope of the Commission that the rhetoric prompted by the issuance of the Interim Report will lead to meaningful

revisions of this part of the system.

It is my intention today to briefly summarize for this Commission the facts and conclusions set forth in the Report, to review the recommendations contained therein, and to respond to some of the unfounded criticisms by various interested parties.

As you know, the Report deals with a highly limited subject matter -- the genesis, promulgation and effect of a schedule which addresses itself to ceilings on rental charges in different types of nursing home operations and the granting of imputed rent or actual carrying charges to certain other types of operators. The Schedule (which is appended to the Report as exhibit I) sets per bed amounts for imputed rents and maximum per bed allowances for other rentals which corresponds to the year of construction of the particular nursing home involved. Multiplying the appropriate dollar amount per bed times the number of beds in the institution results in the rental ceiling, or the imputed rental amount for the individual nursing home's cost report to the Division of Medical Assistance and Health Services.

The obvious interest of the Commission of Investigation was to examine the underlying basis of the schedule, to inquire into the circumstances surrounding its promulgation and to evaluate its function and effect. As a result of the aforesaid inquiry, the S.C.I. established the following facts:

1) New Jersey's schedule of reimbursement of rentals and imputed rentals was based upon an already existing schedule in the State of New York.

2) Officials of the Division of Medical Assistance and Health Services, as of February 1975, did not know what was the underlying basis of the New York schedule.

3) The New York schedule was based on an average of leases then existing and set forth in a study completed by the Metropolitan Nursing Home Association of New York.

4) The leases upon which the New York schedule was based were artificial and inflated via various paper transactions and mortgages in favor of related parties.

5) New Jersey based its urban rental and imputed rental schedule on New York's rural rental and imputed rental schedule but increased the allowance for imputed rentals by 10%.

6) The original impetus for the adoption of the concept of imputed rentals came from the New Jersey Nursing Home Association.

7) The New York Department of Health plans to abandon the idea of imputed rentals within the near future.

8) The savings for the State of New Jersey in bringing New Jersey's schedule in line with the one upon which it was based and/or abrogating the imputed rental concept are substantial.

9) There exists no concrete definition of what is a

related lease as opposed to an unrelated lease, the determination of which has important ramifications for reimbursement purposes.

and, finally,

10) The continuing contact and dialogue by New Jersey with New York on the topic was minimal resulting in a lack of consideration by New Jersey of several salutary changes and adjustments made by New York.

Based upon the foregoing factors, the Commission suggested 1) that the imputed rental column of New Jersey's schedule be immediately reduced by 10% thus bringing it into accord with the schedule upon which it was purportedly based; 2) that ample consideration be given to the complete abrogation of the concept of imputed rentals; 3) that the several adjustments instituted by New York with respect to rentals and carrying charges be considered, including a reduction of imputed rentals for converted nursing homes, a reduction of reimbursement of rent and carrying charges for nursing homes not in full compliance with the building and fire codes and a requirement that nursing homes fund depreciation in excess of mortgage amortization; and finally 4) that as a possible alternative to the utilization of a maximum rental schedule, the Division of Medical Assistance and Health Services study the implementation of a return on capital approach to rental and carrying cost reimbursement.

The foregoing, as has been stated, was an outline of the conclusions and recommendations contained in the Interim Report. Most of these observations, however, are readily

apparent from a reading of that Report. In the balance of this statement I will address myself to various comments and criticisms which have been directed at the Report.

Before I do this, however, I would like to make one point which, it is respectfully submitted, should be marked well by the members of this Commission. I would caution against becoming entangled in a web of controversy over minimal disagreements as to form or figures while ignoring the very real problems of substance pinpointed by the Report. The substantive point made by the Report is that revision of the ill-conceived rental and carrying cost reimbursement system must begin now.

Perhaps the most publicized counter-argument to the Interim Report was that it made miscalculations with respect to the savings which would be experienced by the State of New Jersey if imputed rent was abrogated or if certain reductions were made in the rental reimbursement schedule. The savings projected by the S.C.I. would be experienced as a reduction of the operating expense of each home which figure is a component of the determination of the Medicaid reimbursement rate. Admittedly, it is more correct when speaking of actual dollar savings to the State to apply the percentage of Medicaid occupancy to that figure. Since the issuance of the Interim Report, the S.C.I. has applied percentage occupancy rates submitted by the New Jersey Association of Health Care Facilities and disregarded homes which would continue to receive

the maximum reimbursement rate. The total figure which results from the above computation with respect to fifty-six (or 80%) out of the seventy homes in New Jersey being granted imputed rent is $558,836. I am sure this Commission will hear and has heard other estimates on this figure today, but the critical factor to bear in mind is that the savings, whether it be $550,000 or $700,000 or $900,000, is substantial.

The real issue, then, is whether a substantial number of Medicaid beds would be lost via several nursing homes leaving the program due to the abrogation of the imputed rent concept. There is no credible evidence to justify this self-serving prediction of gloom and doom. It should not simply be assumed that these beds will be lost to the program. Nor should the fact that a nursing home will operate at a loss be decisive because many homes already do. In fact, the average effect on the operating expense of a nursing facility due to the abrogation of imputed rent would be approximately 3% with a corresponding reduction in Medicaid income. A 3% reduction in income seldom spells financial disaster.

Another counter-argument is that the Report compares apples with oranges when it states that New Jersey's urban rental reimbursement schedule is 10% more than New York's rural rental reimbursement schedule. New Jersey metropolitan areas, proceeds the argument, must be compared with New York metropolitan areas. The point which is made in the Report,

however, and which is proven therein is that New Jersey based its urban schedule on New York's rural schedule because of the obvious difference in construction costs between the two states. Thus, in commenting on the similarity and dissimilarity with respect to these two schedules, the Report compares apples to apples.

Another recommendation which might be questioned is that the depreciation reimbursed by the program be funded to the extent that it is in excess of required mortgage amortization. Such a recommendation may be considered inconsistent with conventional accounting practices in the private sector. The recommendation is, however, not so unconventional when one considers that the American Institute of Certified Public Accountants recognized that depreciation should be funded where hospitals receive third party reimbursement based on actual costs and also that the New York Medicaid system, as stated in the Report, has recently promulgated the very same regulation. This recommendation, it is submitted, therefore, should be given serious consideration by the Division of Medical Assistance and Health Services and this Commission.

In conclusion, I would like to reiterate that the Medicaid Program is a highly complex system involving, as you may know, hundreds of millions of dollars of reimbursement, and it is therefore obvious that a variety of inputs will be a necessary prerequisite to the rectification of problem areas.

The S.C.I., however, has become convinced since the outset of this investigation that its role as an independent evaluator dissassociated from the everyday workings of the Program can provide a needed degree of objectivity to the evaluation. Our inquiry is proceeding with all due diligence and we will continue to report or hold public hearings as various facets of the investigation are developed. On behalf of the Commissioners of the S.C.I., I respectfully offer this Commission their continuing cooperation and I now put myself at your disposal for questioning.

SENATOR MARTINDELL: What are the requirements right now for disclosure of ownership of nursing homes?

MR. SIAVAGE: The requirements, Senator, would basically be with respect to the Certificate of Need, upon which are listed the new owners of the nursing home, stockholders of the corporation which would be involved in the operation of the nursing home, etc. I believe there is a contact between I and A and the Department of Health with respect to that information.

SENATOR MARTINDELL: What limits, if any, are placed on the owners by doctors and county social workers or State employees? Are any of them involved to your knowledge ---

MR. SIAVAGE: Not to my knowledge.

SENATOR MARTINDELL: I didn't finish my sentence. (Continuing) --- who may play a role in placing the patients? Do you know what limits ---

MR. SIAVAGE: I think you are referring to a possible conflict between a doctor, for instance, who has a function of placing nursing home patients and who may also have an interest in a nursing home.

SENATOR MARTINDELL: Yes.

MR. SIAVAGE: It has been bandied around that those situations exist. It is difficult for me to comment on anything outside of the four corners of this report, as far as our investigation goes, because there is a disorderly persons statute within our enabling legislation which prohibits that. But I have heard that that situation exists.

SENATOR MARTINDELL: I had prepared a resolution for the Appropriations Committee to cut 10 percent from the imputed rental. Then I talked with Mr. Reilly and he said that he was afraid that that cost would come out of the patient's hide, so to speak. How can you be sure if you do change the formula that that is not going to be the case?

MR. SIAVAGE: I heard that concept set forth this morning. I think the problem with that idea is that it assumes that nursing home operators are operating today at bare bones. In other words, as soon as you cut any proported fat out of the system, the moneys will necessarily affect the patient care. That assumption hasn't been verified however. In other words, what I am saying is that it is not necessarily true that that is going to come out of patient care, any reduction in the amounts presently being received.

The other side to that answer is also that I have heard here this morning suggestions as to improved patient care through various types of inquiries and surveillances by both Institutions and Agencies and Health. I think that has to be stepped up if you cut money for actual carrying charges or rentals, for instance.

SENATOR MARTINDELL: I think they are planning to step it up anyhow. There was one statement you made that confused me a little bit. I think you said that no many nursing homes were making --- Here it is. You said, "Nor should the fact that a nursing home will operate at a loss be decisive because many homes already do." How can they keep going this way?

MR. SIAVAGE: How they can keep going, I can't explain to you. I am sure you are familiar with the fact that several corporations, for instance, in the private sector do actually operate at a loss for tax purposes or other purposes.

That statement, if you are interested, is based on our review of 57 of the homes who were in the 70-home sample, and 20 out of those 57 or approximately one-third are already operating at a loss for I and A purposes. That is from the I and A cost report. So that is the basis of that statement.

SENATOR MARTINDELL: Have your investigations turned up evidence of doctors and vendors getting kickbacks?

MR. SIAVAGE: I have trouble commenting on that statement because of our statute. As you understand, the procedure at the SCI is that the Commissioners decide what is to be made public through any forum whatsoever. This report has been made public by a resolution, but nothing else to do with our investigation has.

ASSEMBLYMAN GARRUBBO: Mr. Siavage, the report that you initially submitted indicates that the reason for the New York imputed rental system was to attract owners of older nursing homes into participation. The imputed rental structure, as I understand it, is one that creates a fictitious type of carrying charge and was based in New York upon average rental agreements. However, your report accurately notes that some of those leases that went to form the average were highly inflated.

MR. SIAVAGE: That is true.

ASSEMBLYMAN GARRUBBO: We found in talking to the Stein Commission people in New York that not only was that a problem, but there were problems of intercorporate relationships where there were common principals, very highly-inflated mortgages, etc. Have you discovered or are

you in a position to discuss with us the extent to which you have discovered any such relationships in New Jersey as were found in New York?

MR. SIAVAGE: Assemblyman Garrubbo, we are involved in that area presently. But I regret for the same reasons expressed to Senator Martindell, I am not prepared today to discuss that with you. Although, of course, when the Commissioners decide that information is ready for public exposure, we will be.

ASSEMBLYMAN GARRUBBO: Mr. Siavage, are you in a position at all - and I don't want to keep prodding you if you are not -- are you in a position at all to discuss any criminal activity that you may have discovered in the course of your investigation?

MR. SIAVAGE: Again, I am not.

ASSEMBLYMAN GARRUBBO: Are you in a position even to indicate that you have or have not found such criminal activity?

MR. SIAVAGE: Not even to confirm or deny it.

I would like to respond though to the beginning of your question which had to do with the fact that the sample of nursing homes in New York --the figure that they came up with was put on the table by Mr. Lowell of the Metropolitan Nursing Home Association in New York, based on a survey that he had done. The only independent evaluation that has ever been done of those figures or, in turn, the New Jersey figures that were based on it was done by Mr. Moan of the Temporary Cost of Living Standards in New York, the same Commission, the Stein Commission, of which we are speaking. I was quite surprised to find in his testimony - and this is in the report before us - that he examined 40 homes, all of which were included in that sample, and found in the majority of the situations, according to his testimony, the situation was the same as the Willaby Nursing Home, which is described in the

report, as far as inflated mortgages and intercorporate transactions between parties.

I think the statement was made before that it has never been demonstrated that the figures in the schedule are invalid. My response to that is, at least to the extent of the investigation done by Mr. Moan, they have been.

ASSEMBLYMAN GARRUBBO: The New York report uncovered a number of nursing homes owned and/or operated by Bernard Bergman. I hate to keep prodding, but I want to know the parameters of your authority today. Are you in a position to discuss whether or not he is the subject of investigation relative to any homes that he may own in New Jersey?

MR. SIAVAGE: I wouldn't be, but I happily can comment on that because in the incipient stages of this investigation we went with Attorney General Hyland on January 3rd, 1975, and it was decided at that time that the Attorney General's Office would look into a "Bergman" connection within the State of New Jersey. It already had been reported in the New York Times that at least four nursing homes had reputed connections with Mr. Bergman. It was decided at that time the Attorney General would conduct that portion of this investigation.

ASSEMBLYMAN GARRUBBO: That has not been within any phase of your function?

MR. SIAVAGE: That is right.

ASSEMBLYMAN GARRUBBO: Have you discussed the proposals that you have made relative to the abrogation of the 10 percent increase over the imputed rental formula or the imputed rental formula with any other division of government? How about the Medicaid people?

MR. SIAVAGE: Yes. We asked Mr. Reilly for his comments on our recommendations. We have received those back and we are presently involved in a dialogue between

his department and our Commission on that.

ASSEMBLYMAN GARRUBBO: Are you in a position to discuss whether or not your investigation has found any evidence of political involvement in either protection of any interest in nursing homes or anything related to the intercorporate relationships?

MR. SIAVAGE: No, I am sorry we are not.

ASSEMBLYMAN GARRUBBO: You cannot comment?

MR. SIAVAGE: I can't comment on that.

ASSEMBLYMAN GARRUBBO: In lieu of the imputed rental formula, were we to abolish it, what would you suggest be utilized?

MR. SIAVAGE: A suggestion is made in the report - it is recommendation number 6, beginning, I believe, on page 49 at the bottom - that the State of New Jersey consider a return-on-capital approach to rental and carrying costs reimbursement. As is explained in the report, what would happen is that we would come up with, through the Division of Medical Assistance and Health Services, a true value on each nursing home and then apply an across-the-board percentage of the property and building costs to that, and reimburse via that method each year to that nursing home. That avoids, to our mind, and certainly has good qualities and is fairly simple, leasebacks, sales, inflated mortgages, etc., because once that cost is determined, other than perhaps plugging an inflation factor, it wouldn't change. So that any machinations between the nursing home being built and the advent of the Medicaid system would be avoided by that program.

ASSEMBLYMAN GARRUBBO: I read the report and I understand your suggestion. I wanted you to put it on the record.

My curiosity has the best of me; I can't wait for you fellows to finish your investigation.

I have to leave at this time, Mr. Chairman. Thank you, Mr. Siavage.

SENATOR FAY: Mr. Siavage, what we have here is the SCI submitting its report, the Nursing Home Association offering its rebuttal, and three people who aren't too hot in long division trying to weigh the matter. We are not about to come to conclusions yet. I am not going to get into formulas and quibbling over a few hundred thousand dollars, but certainly there is a gap. I don't know whether your figures or the Nursing Home Association's figures are right. There are three departments that should answer this: Dr. Finley's, which will get a copy of both reports, Commissioner Klein's, which will also get a copy of both reports; and I am going to personally ask the Office of Fiscal Affairs to go into this. I feel all three of them are in objective, responsible areas to answer these pointed questions and the rebuttal by the Nursing Home Association.

I was operating under the impression until Mr. Coyle told me I was wrong that the only distinction was between the $900,000 figure and the $500,000 figure, and I cannot really grasp that at all. But Mr. Coyle now tells us we are going to lose three million dollars, instead of gaining something. Therefore, third parties are going to have to move in here on what both you and the Nursing Home Association agree is a very complicated and complex situation, as are the corollary problems that go with it. But obviously they are going to be answered, and your call for immediacy is most certainly well taken.

MR. SIAVAGE: Before we leave that, Senator, I would just like to respond briefly to Mr. Coyle's comments. There is no disagreement as of today over the savings of $900,000 versus $560,000, etc. I think we are only $8,000 apart today - $558,000 versus $566,000. So we can settle that.

As I said in the opening statement, however, I

think that the important issue is whether these beds are going to be lost to the program as a result of the abrogation of imputed rental. Mr. Coyle assumes that they will - these homes will all leave the program, all these patients will be transferred, and they will all be transferred into homes receiving presently the maximum Medicaid rate.

The point which I attempted to make in the opening statement was that that is not necessarily true, and this is the type of examination that we called for in this interim report. As I said, you can't consider whether the nursing homes are going to operate at a loss as the result of the abrogation. One thing you can consider is this change in their Medicaid income in operating expenses. As I said, the average is 3 percent.

So I think those factors should be on the record and should be considered by any other body who looks at this matter.

SENATOR FAY: I can assure you they will be. The people responsible will have to answer every question you posed and every recommendation you made in your report. And we are not going to wait three months for them to get around to answering them. The time is now. Every one of these questions is valid. If their objections are valid, they should want to present them as quickly as possible.

That would be my recommendation: to take your report, the Nursing Homes Association's objections and the followup report to the people involved and have them report back to the Commission and the public on them.

MR. SIAVAGE: Thank you very much.

SENATOR FAY: Thank you.

At this time, we will close this session. We haven't as yet set a date for the next public hearing, but we are hoping to have it in the Monmouth-Ocean County

area. Senator Barry Parker has made what I consider a good suggestion; and, that is, to bring the Commission into areas that have a great number of senior citizens and nursing home patients. So I am hoping that the next public hearing will be held in the Monmouth-Ocean County area. Thank you.

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SUMMARY OF PROPOSAL BY DEPARTMENT OF PUBLIC ADVOCATE AND CENTER FOR LAW AND SOCIAL POLICY *

Beginning in the fall of 1974, the Department of the Public Advocate, with the cooperation of the Center for Law and Social Policy, began an examination into the conditions existing in New Jersey's nursing homes and into the operation of the State's regulatory scheme. Our findings convinced us that legislative action and administrative change is urgently needed in this area. The vast majority of nursing homes in New Jersey are not in full compliance with the federal and state statutes and regulations which set minimal standards for a decent and healthy environment for nursing home patients. In many cases, the deficiencies are substantial and of long standing. They cover the gamut from severe understaffing and lack of medical care to unsanitary conditions, poor dietary services and a dearth of any rehabilitative or therapeutic programs.

While the Department of Health has primary responsibility for licensing, regulation and inspection of all nursing homes, the Division of Medical Assistance and Health Services in the Department of Instutitions and Agencies administers the Medicaid program which provides federal and state funds in varying amounts to over 200 nursing homes in New Jersey. The relationship between the nursing facility receiving Medicaid funds and the State is set forth in a contract, known as a provider agreement. In this agreement the State contracts to reimburse the home at a given rate per patient and the home agrees to comply with all applicable state and federal regulations and provide all services set forth in its cost study. The amount of Medicaid funds a home receives per Medicaid patient (the reimbursement rate) depends upon this cost study which the home submits annually to the Division of Medical Assistance and Health Services. However, even if the nursing facility is found to be deficient when inspected by the Department of Health, the State continues to pay the facility the full reimbursement rate as if the nursing home

* The Center represents the National Council of Senior Citizens

were meeting its contractual obligations. Thus, if a home loses personnel or cuts back on its food or services during the year, it continues to be paid at the same rate throughout the year that was determined by the initial cost study. The incentive to cut costs at the expense of patient care in order to increase profits is obvious.

The present utilization by the applicable State agencies of existing remedies has proven to be totally inadequate to raise the level of patient care in the homes and to prevent the wastage of taxpayers' money. In the last few months the Department of Health has threatened several homes with license revocation, although from 1965 to 1974 only ten had their licenses revoked. Revocation of license or Medicaid decertification, which may also put a home out of business, are radical remedies which not only take months if not years, but which also cause patients severe problems of relocation. While state-wide, nursing homes are not filled to 100% capacity, there are severe shortages of beds in some areas. What we propose as a first step to raise the quality of patient care is to take the profit out of noncompliance. While we believe the plan we are proposing can be accomplished administratively under the present statutory structure, new legislation compelling the adoption of the proposed system would be desirable.

The essence of our proposal is that when a Medicaid certified nursing home is not in compliance with standards, the State should withhold from the payments to the home an amount which reflects the value of the omitted service for as long as the deficiency exists. The following method of implementation is suggested:

1. A Joint Deficiency Rating Committee, composed of appropriate personnel from the Department of Health and the Department of Institutions and Agencies should be immediately established.

2. The Joint Deficiency Rating Committee should determine which types of deficiencies can be directly related to specific items on the cost study submitted by all Medicaid providers. A schedule of such costs could be established and reported deficiencies in these areas would result in dollar-for-dollar reductions from the amount the home is reimbursed.

For example, if the average annual cost of a registered nurse is $15,600, a deduction of $300 would be made from the payment to the home for each week in which the home lacked a registered nurse.

3. This Committee would also prepare an interim deficiency rating system for all other deficiencies not susceptible to precise cost analysis. A point value would be assigned to all common types of violations of Medicaid requirements for nursing homes. The amount of points assigned to a particular deficiency would be based upon two criteria:

(1) The impact the deficiency has upon the health and well-being of the patients;

(2) Cost savings to the operator by reason of noncompliance. This information can be gleaned from inspection reports and the cost studies submitted to the Department of Institutions and Agencies.

4. The Committee would develop a schedule of payment reduction based on deficiency point totals and indicate the percentage reduction in per diem per patient Medicaid payment at a given level of deficiency points. For example, a home with a 0-25 weighted point total might still receive full payment, one with 25-50 points a 10% reduction and so on. The point schedule and payment reduction schedule and regulations governing operation of the new system would then be announced and published according to the Administrative Procedure Act requirements.

5. Once in operation, the system will automatically lower Medicaid payments to nursing homes with substantial deficiencies according to the prescribed schedules. The reduced payment will continue unless or until a home demonstrates compliance with regulations so as to reach a level of no reduction or of sufficient compliance to at least raise the level of payment.

6. A home may not delay automatic reduction upon an administrative determination of noncompliance, but it may be entitled to retroactive payments if a subsequent hearing reveals that the determination was in error. We believe that this method is essential to remove the incentive for delay by the noncomplying nursing home. We would additionally advocate that each home, when submitting its monthly claim for Medicaid funds, be required to either certify to the absence of deficiencies or list those which presently exist.

7. After six months, the point and payment reduction schedule should be reviewed, and modified, if necessary, according to operational experience.

The success of such a system will, of necessity, rely strongly upon cooperation by the two Departments involved in nursing home care and particularly upon the adequacy and coordination of the inspection process. We strongly endorse the bill introduced by Assemblyman Garrubbo which would mandate unannounced inspections and inspections pursuant to complaints. We are also in favor of legislation establishing a patient's Bill of Rights and a Nursing Home Ombudsman, which we understand will also be introduced shortly.

We do not claim that our plan is a panacea for all the ills of the nursing home, but we do believe it is a significant step in the right direction toward improving the lives of thousands of our senior citizens confined to nursing homes.

EFFECTIVE ENFORCEMENT OF PATIENT CARE STANDARDS IN NEW JERSEY NURSING HOMES

A Proposal Prepared
by the
Department of the Public Advocate of New Jersey

and

The Center for Law and Social Policy, Washington, D.C.
On Behalf of
The National Council of Senior Citizens

5x

April 1975

Many Americans have come to regard nursing homes with unparalled anxiety, not without good cause. A stay in even the better nursing homes can be a traumatic experience; a stay in the worst can be a nightmare.

Patient abuse and neglect and unsafe and unsanitary conditions are too often found in nursing homes in this State. While we do not mean to imply that all nursing facilities are inadequate, neither are we convinced that most homes in this State are as good as they could and should be and as good as the law requires them to be. Even with the wholly inadequate inspection procedures utilized by the Department of Health, an unacceptable number of violations and deficiences are documented.[1]

Nursing homes have become big business. A report of the United States Senate shows that between 1969 and 1972 the 106 publicly held corporations, which control 18% of the industry's beds accounted for more than $1 billion in revenue per year and experienced growth rates of 112.6% in total assets, 149.5% in gross revenues and 116% in average net income.[1a] In 1974, approximately 200 nursing homes in New Jersey received over $100 million in State and Federal Medicaid funds.[2] In 1973, 82.2% of the 29,603 total beds in nursing homes in this State were occupied for a total of 8,882,191 patient days.[3] Studies now show that at least one out of every five individuals over age 65 will spend some time in a nursing home.[4]

The following analysis and position statement submitted by the Department of the Public Advocate and the National Council of Senior Citizens urges that one way to begin to improve the care of the aged and to reduce the number of existing deficiencies in nursing homes is by taking the profit out of operating illegally. We believe that an analysis of the present Medicaid payment structure reveals that

noncompliance with statutes and regulations translates into increased profits for the owners of the nursing facility. The excess profits being reaped by nursing homes come in large part from the State Treasury.

Briefly, we feel it is clear that the State is and has been paying for nursing home services which have been contracted for but not received. Our analysis indicates that this problem exists on a massive level involving the waste of an enormous amount of public funds and, worse still, the deprivation of life-sustaining services to our elderly in nursing facilities throughout the State. The problem is aggravated by a cumbersome system of regulation that relies on a wholly inappropriate remedy as the sole enforcement device.

This paper suggests an approach which is feasible under present law and which may be accomplished administratively and without substantial time delays, although new legislation may also be desirable. It seeks to accomplish two objectives:

1. First and foremost, to provide a workable regulatory scheme with financial incentives to raise the quality of conditions and care in nursing homes to at least the minimum levels required by law without any additional cost in public funds;
2. To end the wasteful system under which millions of dollars of the tax revenues of the State and Federal Government are paid to nursing home operators who do not deliver the quality and quantity of services required by law and by their contracts with the State.

In essence, we propose that the State of New Jersey institute a system of administrative evaluation of the extent to which a nursing home falls short of meeting minimum standards imposed by law. Since the home has agreed to comply fully with the law, the State should deduct from the Medicaid payment due the noncomplying home a preestablished percentage related to the extent of the noncompliance -- i.e., the State should pay only for value received.

The Nursing Home Industry Today

The plight of senior citizens confined in our nation's nursing homes is not a recent phenomenon. The multiplicity and magnitude of the abuses and maltreatment in nursing homes have been the subject of news media exposes, books, federal and state committee hearings and governmental and private studies. In addition the problems of delivering long term health care have been explored. The nursing home industry's chronic defense has been that more money was needed to remedy deficiencies. However, since the enactment of Medicare and Medicaid in 1965, billions of dollars of public money have been absorbed by the industry. The industry has become a big, lucrative business but the quality of patient care has not improved. Nursing home operators bear the primary responsibility for this failure, but government has also failed in its obligation to the aged.

> Once having taken on the responsibility for older Americans who are sick and poor, the government never exercised the will to ensure the proper carrying out of this responsibility by the institutions . . . [T]he failure of government has been massive at all levels, from federal officials who administer their programs in such a way as to guarantee their ignorance of what is happening to the billions of dollars they spend, down to the local inspectors and case-workers who close their eyes to the abuses they see every day in the nursing homes. The patient lying abandoned in a urine-soaked bed, starved, abused at will by aides, is just as surely a victim of governmental indifference as of the greed of the owner.[5]

The urgency of the need for effective regulation of the industry to provide humane living conditions and adequate medical care becomes clear when one realizes that at least twenty percent of our senior citizens will spend some time in a nursing home. With the advent of Medicaid the financing has become available to provide the needed care. State and Federal governments will spend billions on nursing home care in the years ahead. Both the patients and the public are entitled to have nursing homes deliver what they have promised in exchange for these massive payments.

The aged, those over the age of 65, presently make up ten percent of the population, or approximately 20 million people. This segment of our population is growing faster than any other. Those who reach 65 can expect to live on the average another 15 years.

> At the end of 1971, a little over 5% of the elderly were in institutions. Some 1,106,103 were in nursing homes and about 100,000 were in mental institutions . . ..
>
> . . .
>
> And yet the 5 percent figure is deceptive . . ..The 5 percent figure represents only the number of elderly in nursing homes and related facilities on any given day . . .. A widely published study . . . notes: "While one in 20 seniors is in a nursing home . . . on any given day, <u>one out of five seniors will spend some time in a nursing home during a lifetime</u>." (Emphasis added)[6]

Thus the percentage of senior Americans who will spend some time in a nursing home is at least twenty percent and may continue to rise if the trend to longevity continues.

The growth of the nursing home industry in the years since Medicare and Medicaid has been phenomenal. As of 1970 there were 23,000 nursing homes in this country. By 1974, the United States Senate Subcommittee on Long Term Care reported:

> An even more informative indicator of their growing importance can be shaped from the following new and not generally known facts:
>
> -There are more nursing home beds (1,235,404) in the United States than general and surgical beds (1,006,951).
> -More in-patient days of care were given in long-term care facilities (384.2 million) than in short-term general hospitals (262.7 million).
> -Expenditures for long-term care increased 640 percent from $500 million in 1960 to $3.7 billion in 1973 (less conservative estimates place the nursing home industry's total operating outlays at $6.2 billion).
> -For the first time, Medicaid expenditures in 1972 for nursing home care exceeded payments to general and surgical hospitals: $1.6 billion (34 percent) as compared to $1.5 billion (31 percent).[7]

According to the New Jersey Department of Health, in New Jersey, in April 1975, there were 212 nursing homes with a total of 19,218 beds.[8]

Although the nursing home industry in this country was established by church groups and philanthropic institutions, today these nonprofit facilities run only 15% of our homes, which represents 25% of the beds.[9] Over three-quarters of the industry consists of proprietary homes, i.e., health care facilities operated for profit, and they represent 67% of the available beds. The remaining 8% of the beds in the nation are in institutions operated by governments.[10] In New Jersey, 88% of the nursing homes participating in the Medicaid program are proprietary homes.[11]

Today, the government pays the major cost of nursing home care. "In 1973, about $2 out of every $3 in nursing home revenues came from the public funds. Medicare contributed only $200 million, but Medicaid paid out about $2.1 billion. Private patients paid $1.4 billion. Other sources, including Social Security Benefits, accounted for a sizeable amount, although the exact magnitude is not known."[12] In New Jersey, total Medicaid payments to nursing homes in 1974 were $100 million, half from State revenues and half from the Federal government. In January, 1975, 16,032 patients were supported by Medicaid in New Jersey.[13]

Medicaid pays the major part of nursing home fees because most senior citizens simply cannot afford the charges. In New Jersey, the Medicaid maximum fee of $27.60 per day (approximately $840 per month) is paid to 38% of all nursing homes providing skilled nursing care, the maximum of $26.29 per day (approximately $800 per month) to 40% of all participating homes at ICF Level "A", and the maximum of $23.66 (approximately $719 per month) to 42% of all participating homes at ICF Level "B".[14] Fees to private patients are often higher. In New York, which has no maximum Medicaid fee, charges as high as $1400 monthly have been paid. The private patient with savings soon exhausts them and few have pensions which match the fees charged by nursing homes. Private patients are frequently charged additional fees for services and equipment normally needed for care of geriatric patients.

At these high level charges, the public and the patients have the right to demand that the industry provide at least the quality of care required by law. Government, paying billions to the industry, must ensure that at least legal requirements are met. The United State Senate Subcommittee on Long Term Care has spoken about conditions in nursing homes in its recent report, "The Litany of Nursing Home Abuses," finding the following patterns of abuses:

> Lack of human dignity; lack of activities; untrained and inadequate numbers of staff; ineffective inspections and enforcement; profiteering; lack of control on drugs; poor care; unsanitary conditions; poor food; poor fire protection and other hazards to life; excessive charges...; unnecessary and unauthorized use of restraints; negligence leading to death or injury; theft; lack of psychiatric care; untrained administrators; discrimination against minority groups; reprisals against those who complain; lack of dental care; advance notice of State inspections; false advertising. The Subcommittee's investigations from 1963 through 1974 revealed much the same pattern of abuse as established by the press. However, the bulk of the complaints received fell into the category of poor patient care...
>
> Almost all nursing homes have at least one of the (i.e., category of abuses); some nursing homes have all of them; the vast majority fall somewhere in between... (T)he examples were carefully chosen and were not used unless the principle illustrated is still valid today.

A few of the typical examples offered by the Subcommittee are more than sufficient to remind us of the pressing need for change.

> There was another patient who had trouble walking to the bathroom. He was not incontinent when he came. He had no problem urinating, he just needed some assistance walking to the bathroom. One day the day shift orderly put a catheter in him. The first catheter drew blood instead of urine. So he took it out thinking there was

something wrong with the catheter. So he tried another one. The same result happened. He told me personally to watch the patient because he was bleeding a little bit from the penis. Later on that evening a clot came through his penis that filled the whole bottom of the bed pan. Two or three days later he was sent to the hospital. He died there. at page 170

Self respect is destroyed when a patient is restricted to a regimen of a bath <u>once</u> a week - whether the patient <u>needs</u> it or not - IF it is convenient. Some of the patients who came to . . . [our nursing home] had dirt accumulated in the hair so that the scalp had to be soaked to soften the dirt and then the dirt would be scraped and crumbled by the fingers so that it could be removed without pulling the hair out by the roots. Putrid excreta would be so matted into the pubic hair and between the buttocks that it would have to be soaked repeatedly in soap and water before it could be dislodged with wash cloths and scrubbing brushes. Care had to be taken to prevent damage to the corroded flesh. at page 197

A female patient who was 93, totally blind, and a severe cardiac, was put into a chair with restraints despite doctor's orders that she should be in bed. The day after she entered H. Nursing Home, an attendant struck her in the face with her fist to punish her for spilling a cup of water. Her attending physician called the woman's daughters and had them remove her from the home. She was transferred to her home and died a week later . . .. at page 172

Sometime around the middle of September, the home served hot oatmeal for breakfast. There were worms in the oatmeal. This was not the first time that worms had been found in the food. It usually happens on and off during the summer. . .. at page 179

The Legal and Administrative Structure Presently Governing Operation of Nursing Homes in New Jersey

Over 75% of the beds in nursing homes in New Jersey are certified as eligible for participation in the State's Medicaid (and/or Medicare) program and therefore are subject to both Federal and State regulation.[15] New Jersey Medicaid is a cooperative Federal-State program covering certain "persons whose resources are determined to be inadequate to enable them to secure quality care at their own expense."[16] In 1973, the cost of 54% of all patient-days in nursing homes in New Jersey were paid by Medicaid.[17] Many patients start by paying from personal savings but soon exhaust these resources and become Medicaid patients.

The Medicaid program was established by Title XIX of the Social Security Act[18] and implemented in New Jersey by the New Jersey Medical Assistance and Health Services Act.[19] The Federal government provides a grant to New Jersey of 50% of Medicaid expenditures in the State. To receive this grant, the State must operate its Medicaid program in compliance with the Social Security Act and the rules and regulations promulgated thereunder. The Act expressly requires that a State's Medicaid program must provide skilled nursing home services.[20] The Secretary of the Department of Health, Education and Welfare has promulgated detailed regulations governing care and conditions to be followed in nursing homes certified for participation in Medicaid programs. Some of these regulations are very specific (e.g., frequency of physician visits; employment of licensed nurses and registered nurses) and others are somewhat general (e.g., "a hygienic dietetic service that meets the daily nutritional needs of patients;" an ongoing patient activities program "designed to promote the physical, social and mental well-being of the patients.") The States have the primary responsibility for determining compliance with Federal standards and to periodically inspect all nursing homes. The individual homes must agree to keep necessary records of services to patients and other records required by regulation.[21]

In New Jersey, the operation of nursing homes is governed by both the Department of Health and the Department of Institutions and Agencies. In part such division is mandated by the Social Security Act which requires in effect that the Medicaid program must be administered by the same state agency that administers the federally-funded public assistance programs[22] [in New Jersey, the Department of Institutions and Agencies] but also requires that the state health agency be responsible for "determining whether institutions and agencies meet the requirements for participation in the [Medicaid] program."[23] The New Jersey Health Care Facilities Planning Act (1971) transferred authority for the licensing of nursing homes to the Department of Health.[24] The Commissioner of Health is authorized to adopt rules and regulations governing "standards and procedures relating to the licensing of health care facilities."[25] These are found in the"Manual of Operation Standards for Long-term Care Facilities".[26] Further regulations relating to patient care have been promulgated by the Department of Institutions and Agencies.

These state regulations, found in the New Jersey Administrative Code, are more detailed than the federal regulations. They cover such matters as patient care policies, physician services, nursing services, dietetic services, pharmaceutical services, patient activities, therapeutic services, clinical records, housekeeping services and physical environment.[27]

The authority for the State to participate in the federal Medicaid program is found in the Medical Assistance and Health Services Act. Nursing homa services are included as mandatory services and facilities.[28] The Commissioner of the Department of Institutions and Agencies was authorized to issue all necessary rules and regulations to secure "maximum federal participation that is available with respect to a program of medical assistance consistent with fiscal responsibility."[29] Pursuant to the Act, the State filed with HEW a state plan complying with the requirements of federal laws and regulations.[30]

The Department of Institutions and Agencies has the primary responsibility for the administration of the Medicaid program, the determination of eligibility, and the payment for health services. The Department, through its Division of Medical Assistance and Health Services, enters into provider agreements with each skilled nursing facility and intermediate care facility which accepts Medicaid patients. The provider agreement sets forth the rights, duties and obligations of both the State and the nursing home.

The State agrees to make prompt payments to the facility in accordance with applicable laws and regulations, to keep the facility advised of any changes in Medicaid rules and regulations and to give the facility 30 days' notice of any change in its status as a participating facility.

The facility agrees, among other things, that it will comply with State and Federal Medicaid laws, rules and regulations and permit and assist the Department in determining continuing conformity with applicable State and Federal standards, that it will accept the Medicaid payment as the full payment for the individual covered and that it will provide all services recognized as an element of cost as set forth in its cost study.[31]

In New Jersey, the amount of payment to the individual facility is based upon a cost study each facility submits annually to the Department of Institutions and Agencies. The Department determines which costs are reasonable and from that amount computes the per patient per diem basis which will be paid to the facility for the coming year. If the figure based on actual costs exceeds an "administrative ceiling" set by the Department, the facility receives the amount set by the ceiling. In other words, the facility receives either the amount based on its own past actual costs or the administrative ceiling, whichever is less.[32]

The Enforcement of Standards--Current Practices

It is apparent that there is a host of Federal and State statutes and regulations designed to insure that the sick and the aged will receive quality medical care, humane treatment and a healthy environment when confined to nursing homes. It is equally clear from a review of the studies and legislative testimony and from an examination of a large number of New Jersey inspection reports that many nursing homes in this State fail to meet the legal requirements. The result is that large numbers of patients in nursing homes are subjected to unsanitary conditions, improper medication, insufficient diet and a variety of other indignities and health hazards. Since the legal requirements are extensive, the failure must be in the enforcement process. We submit these conditions are the result of the failure of the regulatory agencies, Federal and State, to utilize the variety of enforcement techniques available. Instead, the regulatory agencies have perceived enforcement as consisting solely of the least useful remedies--license revocation and Medicaid decertification; an all or nothing approach. They have failed to utilize available remedies which can be effective by taking the profit out of noncompliance with required operating standards.

Because compliance with standards increases operating costs, there is an incentive to nursing homes not to provide the required services and conditions. They receive the same flat daily rate even if deficiences are discovered in inspections. Even if the deficiency is immediately corrected, the nursing home has benefited by up to a year of lowered costs resulting from noncompliance with standards. Moreover, the same rate of payment continues even though the home may not correct the deficiency, thereby encouraging delay in compliance. The law requires re-inspections within a short period after the annual Medicaid inspection if substantial violations are found.[33] According to the Department of Health, these follow-up visits are regularly made. However, the inspection reports and complaint files reveal recurrence

of similar violations year after year. In fact, there is no compulsion to ever correct many deficiencies because the only remedies perceived as applicable by the enforcement authorities--closing the home through license revocation or Madicaid decertification--is so severe that it will rarely be invoked. And the payments continue unabated.

The only remedies presently utilized (although rarely) by the regulatory agencies--license revocation and Medicaid decertification--result in closing non-complying nursing homes. Although decertification does not automatically require closing, most nursing homes have such substantial percentages of Medicaid patients that decertification makes continued operation financially impossible. Moreover, generally the same violations of laws and regulations would support both license revocation and Medicaid decertification.

The very severity of the only perceived remedy results in rare utilization. A recent national survey by the New York Times found that "investigations by State and Federal officials are under way in at least 10 states (including New Jersey), but the results thus far have been minimal, with few criminal indictments and only a handful of homes closed for violations."[34] In New Jersey, from 1965 to 1974, only ten nursing homes had licenses revoked through formal proceedings--in five of the ten years, there were no revocations.[35] Moreover, it appears that the homes closed were small operations in the 10-25 bed range, although complete information as to the size of closed homes was not readily available from the Department of Health.

Nursing homes are rarely closed by enforcement authorities for three reasons:

1. Shortage of Beds. In some areas there may exist a shortage of nursing home beds which will be aggravated by closing a home. Or, if no shortgage presently exists, one may be created if a number of homes are closed in the enforcement process. The United States Senate Subcommittee on Long-term Care described the dilemma:

> Why are so few closed? For one reason, State personnel are not prepared to deal with the relocation of patients. "Where will we put them?" was the common cry by State officials. The refusal of many homes to accept welfare patients compounds the problem.[36]

2. Adverse Effects of Transfers on Patients. The very process of transferring patients from one home to another may have substantial adverse effects on the patient's condition. This phenomenon has been termed "transplantation shock." Some experts believe that the shock of uprooting is the cause, and others emphasize attitudes associated with the move. But it appears that transfers result in an immediate short-range increase in death rates.[36a]

In discussing the possibility of closing homes and relocating the patients, a report to the Governor of Michigan stated:

> This enforced wholesale movement of patients can cause great inconvenience and actual physical harm to these patients. Thus, revocation of license adversely affects the very people the Government seeks to serve. For this reason alone, revocation of license must be used only in severe situations when correction of facility inadequacies is demonstrably not forthcoming and the potential harm to the patients if allowed to stay in the facility persisting in those uncorrected deficiencies.[37]

3. The Severity of the Penalty Creates Reluctance and Resistance to Its Use by Agencies and Courts. Closing a nursing home is a financial catastrophe to the owners and operators. It may mean the loss of hundreds of thousands of dollars, not only to investors, but to institutional lenders. As a result, it is not surprising that both enforcement agencies and the courts have been reluctant to close nursing homes. For example, in New York a series of court decisions has made it virtually impossible to close nursing homes. Because of the severity of the consequences, the courts have held that nursing homes must be given hearings before any Medicaid decertification can become effective.[38] These hearings and the subsequent judicial appeals can go on for months or years. All the while the home continues to operate in violation of standards but receives full payment as if in compliance. The result has been a breakdown of enforcement of standards in New York.

One possible alternative available under current law to closing homes is the assessment of penalties for "violating any rule or regulation adopted in accordance with this (Health Care Facilities Planning) Act as the same pertains to the care of patients." Penalties of not less than 10 dollars a day or more than 100 dollars a day are provided. Repeated penalties within one year may result in increased penalties.[39] According to the official of the Department of Health responsible for inspections and enforcement of nursing home standards, no penalty has been assessed within memory.[40] Although no reason is known for the failure to assess penalties, the complexity of the procedures explains why penalties are an ineffective remedy. Before a penalty can be assessed, the department must give 30 days notice of a violation, within which time the nursing home may request a hearing. A full administrative hearing must follow, and a formal written opinion delivered. Only then does the Commissioner of Health assess a penalty. If the offender does not pay, the Commissioner must file a civil action in court under the Penalty Enforcement Act.[41] All of this process consumes months if not years; all the while the non-complying nursing home continues to receive full Medicaid payments. Furthermore, for the larger homes, even the maximum penalty of $100 per day is not an effective deterrent. For a facility of 100 beds, it represents only 3.5% of the Medicaid payment of $27.60 per day. It is conceivable that multiple penalties could be invoked, but past history indicates that enforcement authorities find the penalty and procedures in connection therewith to be un unwieldly remedy.

It does not appear to be a crime in New Jersey for a nursing home to violate regulations relating to patient care. There have been very few prosecutions of nursing home operators anywhere in the nation. To our knowledge, the few prosecutions relate to fraudulent claims for payments, not to violations of requirements for patient care. The criminal process with its complex procedures and severe

sanctions is simply not the proper tool for ongoing regulation of health-care institutions. Criminal prosecutions may be an effective supplement to administrative enforcement, but not a primary technique.

Development of an Effective Enforcement Mechanism

1. To Remove the Profit from Non-Compliance.

2. To Create Incentives for High Quality Nursing Home Care.

3. To Reduce State Expenditures by Reducing Medicaid Payments Proportionate to Failure of Nursing Homes to Comply with Standards.

An adequate legal structure presently exists to bring about marked improvement in nursing home conditions, although additional legislation may also prove helpful. The key to an effective enforcement program is the utilization of appropriate sanctions short of closing homes which will remove the profit incentive for non-compliance with standards. Such a program would also result in savings to the State, for it would no longer be paying the full per diem to homes which are not delivering the full scope and quality of service required by law and by contract. The principle behind such a program is simple: when the State learns, through its inspection process or otherwise, that a nursing home is not in compliance with standards, the State should withhold from the payments to the home an amount which reflects the value of the omitted service for so long as the deficiency exists. In other words, the State should pay only for value received. By accepting Medicaid patients, nursing homes have obligated themselves to provide the scope and quality of services and facilities required by law for the per diem payment under the Medicaid program. If they fail to deliver as promised, the compensation due them should be reduced accordingly.

The obligation of a Medicaid certified nursing home in terms of scope and quality of services is derived from two sources: obligations imposed by law (federal and state statutes and regulations) and obligations assumed by contract. The scope and sources of legal obligations has been discussed above. The contractual obligation derives from a contract known as a "provider agreement" between the state and every nursing home receiving Medicaid payments. Under the provider agreement

the nursing home agrees to accept a specified minimum number of Medicaid patients and accept the level of payment approved under the Medicaid program as payment in full. The home further agrees:

> That it will render all services which have been recognized as an element of cost as set forth in the cost survey (MC-NH1) submitted (the cost survey is based on full compliance)...
>
> That it will comply with State and Federal"Medicaid" laws, and rules and regulations promulgated pursuant thereto.

The provider agreement further states that to participate in the New Jersey Medicaid Program, the nursing home must be licensed and "currently meeting on a continuing basis standards for licensure."[42]

These obligations are also imposed by law. The New Jersey Health Care Facilities Planning Act conditions issuance of a license on operation in the manner required by the Act and rules and regulations thereunder. The regulations under the Social Security Act require nursing homes participating in the Medicaid program to comply with both federal and state regulations.

When a nursing home does not comply with regulations, the Department of Institutions and Agencies should deduct from the payment for the period of non-compliance the reasonable value of the service or portion thereof omitted. The simplest example of such a reduction is where the non-compliance is in the area of personnel understaffing, or the employment of unlicensed personnel when licensed personnel are required. The precise saving in personnel costs can be computed on readily available data, the figures given in the individual home's cost survey. The home has agreed to "render all services which have been recognized as an element of cost as set forth in the cost survey." Or, since the New Jersey reimbursement system for homes receiving the maximum payment is based on average cost, the deduction could be based on the average cost of the service not being supplied. For example, if the average annual cost of a registered nurse is $15,600, a deduction would be made from the payment based on the full average daily rate of $300 for each week in

which the home lacked a registered nurse. From the extensive data available in cost survey reports, a schedule of cost deductions could be prepared, administratively promulgated and placed into effect in a period of months.[43]

There are of course many items of scope and quality of service that cannot be priced with relative precision. However, ample precedent exists for having the determination of value made by an independent hearing office or by a judge. The law regarding rent abatements in New Jersey is directly applicable to the nursing home situation. If a landlord fails to comply with applicable housing codes, the tenant may recover the reasonable value of the lost service, the valuation being made by a judge or jury. A tenant can withhold rent and counterclaim in an eviction proceeding for an implied breach of a warranty of habitability.[44] Similar determinations are regularly made in contract disputes where the seller accepts the goods but asserts a breach of warranty of quality.

We submit that adoption of a payment abatement procedure is not only sound policy but is required by law. The New Jersey Medical Assistance and Health Service Act empowers the Commissioner of the Department of Institutions and Agencies "To recover any and all payments incorrectly or illegally made to a recipient or provider from such provider, the recipient or his estate."[45] The provider agreement expressly authorizes withholding of payments. Paragraph 16 of the agreement provides:

> The Department agrees:
>
> 16. That it will make such payment in accordance with applicable laws and regulations as promptly as is feasible after a proper claim is submitted and approved. <u>However, in the event the Department determines that irregularities, deficiencies, or other similar conditions exist, from any cause, it may withhold payment until such irregularities are adjusted</u>. (Emphasis added.)

A Deficiency Rating Committee, a joint committee of the Departments of Health and Institutions and Agencies should be appointed immediately. This committee would have a mandate to prepare an interim deficiency rating system. This system

would assign a point value to all common types of violations of laws and regulations relating to nursing homes with the exception of Life Safety Code violations.[46] Each violation will be weighted according to two criteria: (1) impact of the deficiency on the living conditions, health and well being of the patients; and (2) cost savings to the operator by reason of non-compliance. There are two primary sources of data available for this formulation--the inspection report of the Department of Health and the Cost Study reports submitted by each Medicaid certified home to the Department of Institutions and Agencies. The Committee should consult with patients and patient groups, nursing home operators, other health care providers and other organizations involved in health care.

Along with the point schedule, the Deficiency Rating Committee should also develop a schedule of payment reductions based on deficiency point totals. This schedule should indicate the percentage reduction in per diem per patient Medicaid payment at a given level of deficiency points. For example, a home with 0-10 points might receive full payment, 10-15 points a 10% reduction, 15-20 points a 15% reduction, and so on. The schedule may include a level of deficiency so high as to trigger a proceeding for license revocation and Medicaid decertification. A point schedule and payment reduction schedule should be announced and regulations should be drafted to reflect the new system. The regulations should be formally published as required by the Administrative Procedure Act. Future provider agreements should contain reference to the point schedule adopted.

Once in operation, the system will automatically lower Medicaid payments to nursing homes according to the prescribed schedule. The reduced payment will continue unless and until a home demonstrates compliance with regulations so as to reach the level of no reduction. Or, the home may demonstrate sufficient compliance to at least lower the payment reduction percentage although still not reaching full payment.

A home which contests the administrative determination of deficiencies (including a determination that deficiencies have not been corrected) will receive an administrative hearing--but the hearing will not stay the reduced payment level. This is essential to remove the incentive for delay by the noncomplying nursing home. Of course, if the hearing finds the determination of deficiency to have been in error, the nursing home receives retroactive payments. The hearings would comply with the Administrative Procedure Act. Additionally, when each home submits its monthly claim for Medicaid payment, it should be required to either certify to the absence of deficiencies or list those which presently exist.[47] This procedure would eliminate the need for hearings as to the existence of deficiencies allegedly found by State inspections since the home would be admitting the existence of the deficiencies.

After six months of operation, the point schedule and payment reduction schedule should be reviewed and modified, if necessary, in light of operational experience.

A plan such as outlined above accomplishes two important objectives that have been noted by the U.S. Senate Subcommittee on Long-Term Care:

1. It creates an enforcement power short of revocation. In its Introductory Report the Subcommittee set forth as a specific recommendation for improvement of inspection and enforcement activities:"State Legislatures should consider additional enforcement powers--short of revocation of licenses--for State agencies";[48]
2. It creates a financial incentive to better care thus responding to the recommendation that:"The present system must be realigned so that greater financial rewards will be available to those nursing homes which provide exemplary care."[49]

It should be stressed that although implementation of our proposal should result in substantial savings of State (and Federal) Medicaid funds in the short-run, the real goal is improvement of patient care in all long-term care facilities in New Jersey. We believe that the current Medicaid reimbursement rates, if utilized legally and properly by the recipient homes, provide sufficient funds to make quality care a reality for all patients.

Inspections of Nursing Homes

No system for regulation of nursing homes can operate without an effective inspection program. New Jersey has the least effective system--pre-announced inspections. We have been advised by the Department of Health that a change to unannounced inspections is being contemplated. It is essential. There are simply too many ways that nursing homes are able to make temporary adjustments at inspection time. Reliance solely on pre-announced inspections gives a distorted picture of the care being provided by the home.

Vigilance is necessary to preserve a truly unannounced inspection system. A nurse recently testified before a Connecticut legislative committee that she was always told in advance by her employer when "unannounced" inspections were to take place. Furthermore, inspections must occur on varied time schedules. Presently, the annual inspection occurs each year in the same period of time before licensing and certification. Under such a schedule, it is simple for nursing homes to prepare for even unannounced inspections.

In addition to the annual inspection, several unannounced inspections should be made each year, some of which should occur after 10 P.M. It has been said that the grossest maltreatment of patients occurs after bed time, when staffing is low and many staff seek to sleep rather than assist patients. The result is patients strapped into bed, unable to reach a bathroom, unable to turn over. The debilitating effects on mental health of such treatment may exceed even the physical damage. To achieve these results we support the legislation proposed by Assemblyman Garrubbo.

Citizen Participation, Patient's Rights and Open Institutions

Although beyond the scope of this proposal, we do not wish to overlook the need for public participation in enforcement of nursing home standards. Most of the public does not have regular contact with nursing homes. Many adults with parents in nursing homes prefer to ignore conditions rather than face up to the difficult question of how to care for an aged and often infirm parent. Public and patient participation must be institutionalized under initiative taken by the State. Statewide and local patient councils should be established. An Ombudsman organization should be created, with authority to conduct its own inspections as a check on the homes and the regular inspectors. Private organizations such as the National Council of Senior Citizens and religious and charitable groups should be permitted to conduct regular recreational, social, intellectual and religious programs in the homes, both for the benefit from the programs themselves to patients and as additional means of obtaining information about conditions. Regular reporting by such voluntary organizations to the Department of Health should be encouraged.

FOOTNOTES

Page 1

1. See Appendix A-3 - A-3(g) which consists of a list of 94 New Jersey nursing homes all of which received Medicaid and/or Medicare funds. We obtained the latest inspection reports of these homes from Region II, HEW, during the winter of 1974-75. After careful study of each report, we compiled A-3 which shows the latest date of inspection (as of Dec. 1974); the number of general deficiencies and the separate number of violations of the Life-Safety Code; whether a post-certification had been made by the time we received the reports, and if so, when; and the major areas in which deficiencies were found.

   Additionally, we inspected the complaint files for a few homes and discovered that the same violations were being complained of year after year: e.g., gross understaffing, lack of medical care; inadequate diet; dearth of activities or rehabilitative training; theft of patients' Medicaid allowances; unsanitary conditions, etc.

   A report of the Division of Medical Assistance and Health Services of I & A released in May 1973, while concluding that homes are generally better in New Jersey than elsewhere, also pointed out the large number of serious deficiencies in a number of homes (pp. 20-34).

1a. Subcommittee on Long-Term Care of the Special Committee on Aging, United States Senate, Nursing Home Care in the United States: Failure in Public Policy, Supporting Paper No. 9, "Profits and the Nursing Home: Incentives in Favor of Poor Care" (to be released shortly).

2. Contained in a letter dated March 27, 1975, from Gerald Reilly, Director, Division of Medical Assistance and Health Services, to the Department of the Public Advocate. The following figures were supplied:

	State's Share of Medicaid Expenditures for Nursing Homes	Number of Medicaid Providers as of January 1
1970	$17,000,000 (estimate)	230 (estimate)
1971	$35,000,000 (estimate)	225 (estimate)
1972	$40,565,000	210
1973	$45,229,000	230
1974	$50,889,000	223

In 1973, expenditures for nursing home care was the largest single type of expenditure under the Medicaid program. 1973 Annual Report of the New Jersey Health Services Program, pp. 18-19. The Department

of the Public Advocate and the National Council of Senior Citizens, having no regulatory authority over nursing homes, have relied upon figures supplied by the various other state agencies. We were not able to determine precise nursing home statistics in the state because conflicting figures are supplied by various officials in the Departments of Health and Institutions & Agencies.

3. Projected Long-Term Care Bed Need, prepared by Department of Health, Health Facility Planning, Office of Comprehensive Health Planning. In a subsequent status report of July 3, 1974, to Region II, Regional Division of Long-Term Care Standards Enforcement, Department of Health, Education and Welfare, Institutions & Agencies reported slightly over 23,000 total beds.

4. Subcommittee on Long-Term Care of the Special Committee on Aging, United States Senate, Nursing Home Care in the United States: Failure in Public Policy, Introductory Report, December, 1974, p. 15.

Page 3

5. Mendelson, Mary, Tender Loving Greed, (Alfred A. Knopf. 1974) pp. 37-38.

Page 4

6. See footnote 4.

7. Senate Subcommittee Report, supra, footnote 4, at p.20.

Page 5

8. Information supplied by Department of Health to Department of the Public Advocate on April 11, 1975.

9. Introductory Report, footnote 4, supra, at p. 22.

10. Id.

11. On April 16, 1975, the following figures were received from the Bureau of Claims and Accounts: 231 nursing homes participate in the Medicaid program, 204 of these are proprietary. Note, this figure conflicts with the Department of Health figure - footnote 8.

12. Introductory Report, footnote 4, supra, at p. 25.

13. Report prepared by Division of Medical Assistance and Health Services, Institutions & Agencies, January, 1975. The breakdown by level of care was:

Skilled Nursing Homes - 896 patients
ICF (Level A) - 10,859 patients
ICF (Level B) - 4,277 patients

14. On April 16, 1975, the Bureau of Claims and Accounts stated that there were 218 participating facilities providing skilled nursing care, 231 providing ICF "A" and "B". Reimbursement rates were determined from an analysis of the Bureau computer print-out dated January 10, 1975, which indicated 82 Skilled Nursing Facilities, 92 ICF "A" facilities, and 96 ICF "B" facilities being reimbursed at the rate of the administrative ceiling.

Page 8

15. Figures supplied by Division of Medical Assistance and Health Services (Medicaid) indicated that in September 1974 there were 19,125 nursing home beds, 15,700 of which were certified for Medicaid payments. Another 1,657 beds were certified for Medicare only.

16. Medical Assistance and Health Services Act, N.J.S. 30:4D-2.

17. This figure was arrived at by dividing the figure for total nursing home days provided by Medicaid as reported in the 1973 Annual Report of the New Jersey Health Services Program (at p. 35) by the figures reported by the Department of Health (see footnote 3, supra).

18. 42 U.S.C. § 1396 et seq.

19. N.J.S. 30:4D-1 et seq.

20. 42 U.S.C. § 1396 a(a) 13 (A) and (B): U.S.C. § 1396 d(a) 4 (A).

21. 42 U.S.C. § 1396 a(a) 27; 42 U.S.C. § 1396 a(a) 30.

Page 9

22. 42 U.S.C. § 1396 a(a)(5).

23. 42 U.S.C. § 1396 a(a)(9)(A).

24. N.J.S. 26:2H-19 and 22.

25. N.J.S. 30:11-1.7.

26. N.J.A.C. 8:30-1.1 et seq.

27. Skilled Nursing Home Services Manual, N.J.A.C. 10:63-1.1 et seq.; Manual for Standards for an Intermediate Care Facility, N.J.A.C. 10:65-1.1 et seq.

28. N.J.S. 30:4D-6(4)(a).

29. N.J.S. 30:4D-7.

30. N.J.S. 30:4D-14.

Page 10

31. 1974-75 Provider Agreement, MCNE-33, Rev. 5/74 (Appendix A-1).

32. The current administrative ceiling is set forth in Long-Term Care Facility Circular Letter #45 dated July 1, 1974, from Herbert L. Glover, Chief, Bureau of Claims and Accounts of the Division of Medical Assistance and Health Services.

Page 11

33. 45 C.F.R. 249.33; 20 C.F.R. 405.1903.

Page 12

34. March 31, 1975, p. 1.

35. Conversation with Arrie DuShane, Chief, Facility Survey and Licensing, Department of Health, February 18, 1975. Note that in the last two months an increasing number of homes have been threatened with loss of license by the Department of Health.

Page 13

36. Senate Subcommittee Report, see footnote 4, supra, at p. 82.

36a. This is not to suggest that a home should never be closed or patients transferred. Under carefully planned moves in which the patient is adequately prepared for the change, the transplantation shock can be substantially diminished. Pennsylvania has introduced such a program using specially trained teams of relocation specialists. Aging No. 233-34, Mar.-Apr. 1974, p. 13.

37. Id.

38. Maxwell w. Wyman, 458 F. 2d 1146 (2nd Cir. 1972); Hayden Manor Nursing Home v. Lavine, New York Law Journal (Jan. 23, 1973) p. 2, Col. 4 (N. Y. Supreme Court, N. Y. County).

Page 14

39. N.J.S. 26:2H-14.

40. See footnote 35. Subsequent to this conversation, on February 25, 1975, Hilltop Nursing Home, Middletown, New Jersey, was fined $1,000 by the Department of Health for "willful falsification of records for purposes of concealing inadequate nursing coverage." The fine, however, was not simply for deficiencies discovered.

41. N.J.S. 26:2H-16; N.J.S. 2A:58-1.

Page 17

42. See footnote 31 (Appendix A-1)

Page 18

43. The cost survey form is attached as Appendix A-2 - A2 (dd).

44. Marini v. Ireland, 56 N.J. 130 (1970); Berzito v. Gambino, 63 N.J. 460 (1973).

45. N.J.S. 30:4D-7h, Medicaid funds have never been withheld pursuant to paragraph 16. Letter cited at footnote 2.

Page 19

46. We have eliminated Life-Safety Code violations from our proposal, because enforcement thereof is primarily a Federal responsibility and the Department of Health, Education and Welfare has the exclusive authority to grant waivers based on substantial compliance. Note, the SCI has made certain suggestions in this area in its April 3, 1975, Interim Report.

Page 20

47. The filing of a false certification should carry criminal penalties.

48. See footnote 4, supra, at p. 111.

49. Subcommittee on Long-Term Care of the Special Committee on Aging, United States Senate, 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 (Dec. 1974), p. 227.

APPENDIX

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

For Division Use Only

_____ Twelve Month Agreement
_____ Six Month Agreement
_____ Other _____
_____ Medicare-Medicaid
_____ Medicaid Only

Levels of Care

_____ Skilled Nursing Facility

_____ ICF-Level A

_____ ICF-Level B

1974-1975 AGREEMENT
SKILLED NURSING AND/OR INTERMEDIATE CARE FACILITY PARTICIPATION IN THE HEALTH SERVICES PROGRAM

(Name of Facility) _____

(Address) _____

(Facility License No.) _____ Title XIX Provider No.: SNF _____
ICF-A _____
ICF-B _____

This Contract, made and entered into by and between the Department of Institutions and Agencies through the Division of Medical Assistance and Health Services, hereinafter designated as the Department, and the above named facility, a provider of services, whose address is as stated above, hereinafter designated as the Facility, Witnesseth:

WHEREAS, various persons eligible for benefits under the New Jersey Health Services Program (Medicaid) are in need of medical care in the form of Skilled Nursing Facility care, or Intermediate Nursing Care, as more specifically set forth in Program regulations and guidelines; and,

WHEREAS, Section 1902(a)(27) of Title XIX of the Social Security Act requires states to enter into a written agreement with every person or institution providing services under the State Plan for Medical Assistance (Title XIX); and,

WHEREAS, pursuant to N.J.S.A. 30:4D-1 et seq., the Department is responsible for the administration of the Medicaid Program, and is authorized thereunder to take all necessary steps for the proper and efficient administration of the New Jersey Medicaid Program; and,

WHEREAS, to participate in the New Jersey Medicaid Program, a Skilled Nursing Facility and/or Intermediate Care Facility must: (1) be licensed under the laws of New Jersey; (2) be currently meeting on a continuing basis standards for licensure; (3) be administered by a licensed nursing facility administrator who holds a current license; (4) meet on a continuing basis Federal and State standards for participation in Title XIX; (5) accept the terms and conditions of participation set out herein.

NOW, THEREFORE, in consideration of the mutual promises herein contained, it is agreed by and between the parties hereto as follows:

A. FACILITY AGREES:

1. That it will render all services which have been recognized as an element of cost as set forth in the cost survey (MC-NH 1) submitted;

2. That it will accept the payment approved under the Medicaid Program, based on the level of care required by the eligible individual, as payment in full and will not make any additional charges to the patient or others on his behalf;

3. That it will promptly initiate and terminate billing procedures when individuals covered under this program enter or leave the facility or are assessed at a different level of care, pursuant to applicable regulations;

4. That it will limit billing procedures under this Program to those eligible and authorized recipients that have been placed in the certified section of the Facility;

5. That it will make available to the appropriate State and Federal personnel or their agents, at all reasonable times and places in New Jersey, all necessary records, including but not limited to the following:

   a. Medical records as required by Section 1902(a)(28) of Title XIX of the Social Security Act, and any amendments thereto;

   b. Records of all treatments, drugs, and services for which vendor payments are to be made under the Title XIX Program, including the authority for and the date of administration of such treatments, drugs, or services;

c. Documentation in each patient's record which will enable the Department to verify that each charge is due and proper prior to payment;

d. Financial records of the Facility;

e. All other records as may be found necessary by the Department in compliance with any Federal or State law, rule, or regulation promulgated by the United States Department of Health, Education and Welfare, or by the Department.

6. That it will accept a minimum of _____ recipients of the Medicaid Program, subject to availability of beds, in any combination of the following levels of care: (Check appropriate box(es) for level of care in which facility will participate.)

☐ Skilled Nursing ☐ ICF-Level A ☐ ICF-Level B

7. That it will cooperate fully in permitting and assisting representatives of the Department to make assessments and evaluations of services provided to patients generally, and of the needs and circumstances of individual patients who are recipients of medical assistance.

8. That it will secure and arrange for other health services for Medicaid patients pursuant to Program regulations as may be available;

9. That it will comply with State and Federal "Medicaid" laws, and rules and regulations promulgated pursuant thereto;

10. That it will cooperate fully in permitting and assisting representatives of the Department in determining continuing conformity with the Federal and State standards applicable to "Skilled Nursing Facilities" and "Intermediate Care Facilities";

11. That it will comply with the requirements of Title VI of the Civil Rights Act of 1964 and any amendments thereto;

12. That it will notify the Bureau of Claims and Accounts, Division of Medical Assistance and Health Services, within five working days, of any change in the status of its license to operate as issued by the Department of Health;

13. That it will not initiate, request, or otherwise cause the removal of a Medicaid patient for the purpose of making an additional bed available for private paying or other non-Medicaid patients, except upon valid reason submitted to and approved by the Departm

14. That breach or violation of any one of the above provisions shall make this entire agreement subject to immediate cancellation at the Department's discretion, in keeping with the Fair Hearing procedure adopted by the Division in accordance with the New Jersey Administrative Procedures Act.

B. DEPARTMENT AGREES:

15. That it will pay for authorized services provided by the Facility on the basis of the level of care required by the eligible individual as determined by the Department, but in no event will payment be made for any individual determined not to require skilled nursing or intermediate nursing care.

16. That it will make such payments in accordance with applicable laws and regulations as promptly as is feasible after a proper claim is submitted and approved. However, in the event the Department determines that irregularities, deficiencies, or other similar conditions exist, from any cause, it may withhold payments until such irregularities are adjusted;

17. That it will make proper adjustment in the vendor payments, as is indicated, to compensate for either overpayment or underpayment;

18. That it will give, subject to paragraph 14, the facility 30 days' notice of any impending changes in its status as a participating Skilled Nursing and/or Intermediate Care Facility;

19. That it will notify the Facility of any change in Title XIX rules and regulations, and to work with the individual Facility with the view toward providing the best care available within the limitations of the law and available money;

20. That the facility may terminate its participation in the Medicaid Program upon a minimum of 60 days' notice to the Department.

C. DEPARTMENT AND FACILITY MUTUALLY AGREE:

21. That, in the event the Federal and/or State laws should be amended or judicially interpreted so as to render the fulfillment of this agreement on the part of either party infeasible or impossible, or if the parties to this agreement should be unable to agree upon modifying amendments which would be needed to enable substantial continuation of the Title XIX Program as the result of amendments or judicial interpretations, then, and

in that event, both the facility and the Department shall be discharged from further obligation created under the terms of this agreement, except for equitable settlement of the respective accrued interests up to the date of the termination;

22. That this agreement shall not be transferable or assignable and the agreement shall be null and void upon a change in ownership and/or operation;

23. That, in the event a participating facility is sold, the Department shall make no decision of the reimbursable proceeds for services rendered to Medicaid recipients between vendor and vendee, but rather will reimburse the provider of record as of the billing month for all services rendered. Said provider shall make the necessary adjustments;

Note: Item 24 to be completed by the Division.

24. This agreement shall be effective on _____ and terminate on _____ unless terminated prior thereto (1) by mutual consent of the parties, (2) for cause under applicable clauses herein, or (3) because of Federal and/or State government withdrawal from Program participation.

_____
(Facility)

_____
(Address)

_____
(Authorized Signature)

_____
(Title)

_____
Division of Medical Assistance
and Health Services
Department of Institutions & Agencies

State of New Jersey
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

1975 COST STUDY FOR LONG TERM CARE FACILITY SERVICES - INSTRUCTIONS

General

The period covered by this Cost Study must be the Facility's latest natural twelve-month period. This form is a modification of that designed for Skilled Nursing Facilities and will be used to establish rates for Intermediate Care Facilities levels "A" and "B" as well as for Skilled Nursing Facilities, therefore, it is essential that information pertaining to levels of care be answered as accurately as possible.

The completed Cost Study and a photostatic copy should be submitted to the Department of Institutions and Agencies, Division of Medical Assistance and Health Services, Bureau of Claims and Accounts, Box 2486, Trenton, New Jersey 08625 by April 15, 1975. A duplicate copy is enclosed for your retention.

The following schedules and exhibits, which comprise this Cost Study are to be completed by all facilities except as otherwise indicated:

Page		
1	Certification	General Administrative Information
1-5	Schedule A	General and Statistical Information
6-9	Schedule B	Statement of Operations (Income & Expense)
10	Schedule B-1	Reconciliation of Gross Salaries
11-12	Exhibit I	Administrative and General Expenses
13-14	Exhibit II	Income Offsets and Non-Allowable Expenses
15	Exhibit III	Computation of Allowable Administrator's Salaries
16	Exhibit IV	Imputed Rental (To be completed by Proprietary nursing facilities participating in related * rentals or those not renting their facilities)
17	Exhibit V	Real Property Expenses and Return on Equity (To be completed by nursing facilities not renting or with related* leases. Note: Voluntary and Governmental facilities are not entitled to return on equity, but should complete the Real Property Expense section of Exhibit V.)
18	Exhibit VI	Building Rental (To be completed by all nursing facilities with unrelated ** leases only)

* Related - Affiliated through common ownership or control
** Unrelated - Third party transactions

Facilities containing units other than identifiable long term care units should confine the information submitted to the long term care units only. Schedule B, Column 4 should contain only those costs allocated to the long term care unit from the information supplied in Schedule A, question C.

All questions must be answered. If the answer is NONE or NOT APPLICABLE, please write NONE or NOT APPLICABLE.

1. Certification

   a. Provider #s- The 5 digit numbers assigned to each nursing facility under the Medicaid Program. (Should be used throughout the Cost Study)

   b. Signatures - The Cost Study must be signed by both the preparer and owner/officer of the nursing facility. If owner/officer prepares the Cost Study he should sign both places.

OMIT CENTS on ALL schedules and exhibits.

The nursing facility must maintain for audit purposes, for the period covered by this cost study: (if applicable)

   a. General Ledgers
   b. Books of Original Entry:
      (1) Cash Receipts
      (2) Cash Disbursements
      (3) Patient Charges (Accounts Receivable)
      (4) Purchases or Voucher Register (Accounts Payable)
      (5) Payroll Registers
      (6) General Journal
   c. Individual patients' income and personal incidental records
   d. Invoices in support of expenses
   e. Federal Income Tax Returns
   f. N. J. Corp. Business Tax Return (Form CBT-100)
   g. Payroll Tax Returns (N. J. UC27-B, Fed. Form 940, Fed. Form 941)
   h. Worksheets used by nursing facility to combine and/or allocate costs for the preparation of this Cost Study. These worksheets must be reconciled to the General Ledger
   i. Details affecting accrued expenses at beginning and end of period
   j. Depreciation schedules
   k. Daily Census records
   l. All other supporting information particular to this Cost Study

2. Schedule A - General and Statistical Information

   a. Type of Facility - Check all identifications that apply.
   b. Type of Ownership - Proprietary means a facility operated for compensation and profit. The type of proprietary facility must also be indicated. Voluntary means a facility operated by a "non-profit" association or corporation. Governmental means a facility operated by a branch of the government.
   c. Combination Facilities - If the facility contains other than an identifiable long term care unit, attach a schedule showing the total costs as recorded in the books of accounts and the amounts allocated to the long term care unit with the method of allocation indicated; Schedule B, Column 4, should reflect only the allocated

costs pertaining to the long term care unit, therefore, Schedule A, question j, should reflect only those patient days pertaining to the long term care unit.

d. Audit - A copy of the facility's latest audit or review by an independent Public Accountant for the same period as the cost study, must be submitted.

e. Administration - If owners, officers or administrators are connected with another facility participating in the New Jersey Medicaid Program, enter the names, facilities associated with, provider numbers, numbers of beds, primary duty and salary of individuals at other related facilities. (See Instructions for Exhibit III)

f. Residency- If any owner/officer, administrator or member of their family resided on the nursing facility's grounds, all expenses connected with this residency must be segregated from the operating expenses of the facility. Amounts segregated for living expenses of owners/officers or administrators must be considered additional compensation and added to salaries paid when computing allowable administrator's salaries. Amounts apportioned and the basis for apportionment must be explained on a separate schedule.

g. Owners/Officers' Families on Payroll - Reasonable* compensation paid for actual and necessary performed services will be allowed providing family members are identified in this section.

h. Purchased Services - Indicate all services purchased from organizations with common ownership or relationship. Attach statement showing compensation or fee paid.

i. Owners/Officers - List all owners and officers and give primary duty of each, number of hours performed, and amount paid. Reasonable* compensation paid will be allowed for services actually performed in a necessary long term care facility function. Proprietorship or partnership owners' salaries not formally specified may be included at a reasonable* amount even though unpaid; however, a full declaration of each claim must be shown.

j. Patient Days - Indicate the daily rates now being charged for semi-private accomodations in each classification. The actual patient days must be the total days of care rendered to all patients during the identical period for which costs have been reported on Schedule B. All classification of patient days must be broken down by level of care. Statistics must be accurate, not "estimated".The number of beds must agree with licensed capacity and should include the "quiet" room. If the percent of occupancy calculated in j9 is below 80% or over 95% compute j10 or j11. The actual patient days will be adjusted by this Division when computing the per diem rate if below the 80% or above 95%. In those instances when the actual occupancy rate is in excess of 95%, the reimbursement rate will be computed using the 95% of maximum bed days. This procedure will result in a higher reimbursement rate than normal for those homes maintaining a high occupancy. In those instances when the actual patient days are under 80%, the variable expenses will be adjusted, if deemed necessary.

k. Date of Construction - Indicate the year the original building was completed and the original cost. All additions (new construction) adding to the licensed bed capacity should be indicated separately

* Reasonable - means an amount that would be paid for comparable necessary services by comparable facilities in this State.

showing the year completed, number of beds added, and original cost. The year that the facility was first converted or occupied as a long term care facility must not be used in lieu of the year the original building was completed.

1. Accounting System - Indicate the basis used on the cost study statements. If different than used for Federal Tax purposes, attach explanations. When a reporting basis has been established, all future cost studies are to use the same basis. Reversals of prior year accrual adjustments must be reflected in current year costs.

m. Salaried Physicians, Therapists, and Pharmacists - List the names and salaries of all physicians, therapists, and pharmacists not on a fee basis and identify the expense classification. (Must agree with Schedule B).

3. Schedule B - Statement of Operations

a. Income - Reflect actual income as recorded in your books of account, for the period of this cost study. The period must agree with that used in computing actual patient days as in Schedule A. In those instances where the facility has not been in operation for a period of twelve months, an abbreviated period may be used.

1. Room and Board and Routine Care - Indicate income from each classification separately. (by level of care)

2. Other Income from Private, Medicare and Medicaid Patients Indicate income from each classification separately.

3. Miscellaneous Income - All other income should be included here. If the individual line items do not encompass all items of income, a statement of other income must be attached.

Income items which represent refunds or reductions of cost and/or activities which are not properly chargeable to patients' care, must be indicated in Exhibit II and offset against expense claimed in Schedule B.

Examples - covered by this provision include:

a. Telephone charges
b. Private nursing service
c. Hand feeding
d. Interest on Unrestricted Investments
e. Receipts from employees for value (i.e.) rental of living quarters, employees meals, laundry, etc.
f. Purchase discounts
g. Property or equipment rentals
h. Items sold for use outside the medical facility

b. Expenses

Reflect actual expenses as recorded in your books of account. Exhibits I through VI should be completed prior to Schedule B, since much of the information on these Exhibits is transferred to this Schedule.

Total salaries must be reconciled (Schedule B-1) between Schedule B, Column 1 and gross salaries as reported on Federal Forms 941 and 1099. Reconciliation must reflect separately the accrued salaries, if any, at the beginning and end of period. Earnings of partners as stockholders in subchapter s corporations that are included in Schedule B, Column (1), must also be shown separately. Complete photostats of forms 941, for the tax quarters reported in the Cost Study, must be submitted. Indicate the number of employees in each salary classification, also whether employees are full time or part time as of December 31, 1974.

Medical Supplies - under Health Care (3d) refers to incontinency pads, bandages, dressings, compresses, sponges, plasters, tapes, cellucotton, or other types of pads used to save labor or linen, and other disposable items (e.g. colostomy bags) also, hot water bags, thermometers, catheters, rubber gloves, and supplies required in the administering of medication, including disposal syringes. (DO NOT INCLUDE DRUGS)

Drugs - under Health Care (3f) refers to prescribed drugs, intravenous solutions, medicine chest supplies and personal comfort items, (e.g. mouthwash, talcum powder, massage lotions, etc.) also drugs under Medicare.

Column 3 of Schedule B should be completed by carrying forward the amounts shown in Exhibit II, Column 3. Schedule B, Column 4 is the sum of Column 1 and 2 minus Column 3.

4. Exhibit I - Administrative and General Expenses

a. Salaries - List name, License Number, and Salary of Administrator and Assistant Administrator. The total salary of the Administrator and Assistant Administrator is subject to limitations as per the schedule attached page K. Adjustments for excess salaries should be entered on Exhibit II. When administrators, owners or officers are affiliated with two or more participating nursing facilities, see Exhibit III.

b. Taxes - List all taxes other than Income Taxes. Federal and State Income Taxes are non-allowable. They should be entered on Schedule B, miscellaneous expense, and offset by adjustment on Exhibit II. Do not enter Income Taxes in this section.

c. Insurance - List all insurance other than on real property. Real Property Insurance is entered on Exhibit V or VI.

d. Other Administrative Expenses

1. Interest Include interest other than that related to real property. Attach schedule listing payee, date of loan, principal, term and interest rate. Interest paid to a lender related through control, ownership or personal relationship is not allowable and should be adjusted on Exhibit II. Interest on real property should be recorded on Exhibit V.

2. Depreciation - Include depreciation on straight line basis on medical equipment, office furniture and equipment, vehicles and land improvements only. Depreciation on real property must be reported on Exhibit V. Depreciation on Building Improvements which did not increase bed capacity should also be recorded on Exhibir IV. (See Instructions for Depreciation, pg. h)

7. Advertising - Only personnel recruitment and bold print, yellow page allowable. Enter amount which is non-allowable on Exhibit II.

8. Travel - Only that travel on official nursing facility business is allowable. Commutation expense between facility and private residences is not an allowable expense and must be deducted on Exhibit II.

9. Legal Expenses - Reasonable legal expenses incurred in the course of nursing home operations are allowable. Legal expenses which arise from civil and/or criminal actions between facility and state or federal governmental agencies are not allowable (other than by court order), and must be deducted on Exhibit II.

11. Miscellaneous - Attach a list of other administrative expenses which could not be properly classified in one of the specified categories. Donations to volunteer fire companies, first aid squads and church groups for services rendered should be listed as a miscellaneous expense and are allowable. Director's fees are allowable, however, limited to $50. per director (max. 5) per meeting (max. 4).

5. Exhibit II - Income Offsets and Non-Allowable Expenses

Record all items of income to be offset against charges to the extent of the expense, and all items of non-allowable expenditures. Indicate the line of Schedule B, Column 3, on which these costs have been deducted. The total of income offsets and non-allowable expenses should agree with Schedule B, Column 3. This Exhibit must be completed by all nursing facilities.

6. Exhibit III - Computation of Allowable Administrators' Salaries

The time of owners/officers and administrators who work at two or more related facilities must be allocated. Allowable salaries are computed based on the amount of time spent at the related facilities.

a. List the Medicaid provider numbers and the names of the related facilities in columns (1) and (2).

b. List the owners/officers and administrators and allocate the percentage of time worked at each of the related facilities in columns (3) through (8). No person can allocate more than 100% of their time. If a person also works at other activities or non-participating facilities, a portion of their time must be allocated to this activity.

c. Add the total percentages allocated to each facility and list in column (9). Note: The total % of column (9) must equal the total number of people listed, multiplied by 100%.

d. List the Medicaid provider numbers, the names and the licensed bed capacities of the related facilities in columns (10), (11) and (12).

e. Enter the amounts allowable in columns (13) and (14) per page k of instructions for the licensed bed capacities of each facility. If a facility has a capacity of less than 75 beds, enter the amount from column I, page k, in both columns (13) and (14).

f. Compute the difference between column (14) and column (13) and enter in column (15) for each facility.

g. Enter the % in excess of 100% in column (16) for each facility per column (9). If a facility has less than 100% in column (9), enter 0 in column (16). If a facility has more than 200% in column (9), enter 100% in column (16).

h. Compute the maximum allowable administrator's salaries and enter in column (17) for each facility. The maximum allowable for each facility is column (13) plus the percentage indicated in column (16) of column (15). ((13) + (16) % of (15)).

i. Enter the total paid owners/officers and administrators plus any additional compensation per Schedule A, line f, in column (18) for each facility.

j. Enter the excess of column (18) over column (17) for each facility in column (19). The excess must also be reported in Exhibit II, line g.

7. Exhibit IV - Imputed Rental Computation

All proprietary nursing facilities involved in rentals with related lessors and those not renting their facilities have the option of using imputed rentals in lieu of certain actual real property expenses and return on equity. Imputed rentals should be calculated separately for each new construction adding beds to the licensed capacity. Rates for each year are included on page 1 of these instructions; however, rates for additions are subject to approval by this Division. In addition to imputed rentals, the amount of depreciation on building improvements which did not add to the bed capacity should be added on line 7. With the exception of Real Estate Taxes, all other real property expenses must be eliminated when using Exhibit IV. For further instructions, see page i.

Exhibits IV and V should be completed for all facilities where the nursing facility property is owned rather than rented by the operator. Only the larger of Exhibit IV, line 8 or Exhibit V, line 2j should be transferred to Schedule B.

The imputed rental policy offers options to the nursing facility as follows:

a. Nursing facilities renting from unrelated third parties must use actual rent paid, subject to limitations per schedule of maximum rents by area. (page 1 columns a or c).

b. Nursing facilities renting from related lessors may use total imputed rental and depreciation on building improvements per Exhibit IV or the actual real property expenses paid for the nursing facility on the books of the controlled lessor, i.e. depreciation, insurance, real estate taxes, utilities, and equity on real property (Exhibit V).

c. If the real property of the nursing facility is owned by the operator, the facility may use the actual real property expenses as recorded plus an allowed return on equity in real property per Exhibit V or the imputed rents and depreciation on building improvements per Exhibit IV.

8. Exhibit V - Real Property Expenses, Including Return on Equity

Include all real property expense in this exhibit.

a. Mortgage Interest - All interest paid on notes or loans financing real property owed to a lender not related through control, ownership, affiliation or personal relationship should be shown here. All other interest should be shown on Exhibit I and non-allowable interest to related lenders should be eliminated on Exhibit II.

b. Depreciation on Real Property - Depreciation on real property should be entered here at the straight line amount only. Where records of related lessor are used for Equity Computation (proprietary facilities only), balance sheets of the related lessor must be submitted.

c. Insurance on Nursing Facility Buildings - Only building insurance should be included here. All other insurance should be entered on Exhibit I.

9. Exhibit VI - Building Rental (Per Lease Contract)

The limitation on building rental expense creates a need to separate other expenses from all inclusive rentals. Where the rent paid includes movable equipment and other expenses, deduct these to arrive at a net rental of real property. List the other expenses separately on Schedule B under property expense or plant operations. Unrelated rental transactions entered into prior to 1/1/71, will be allowed, if paid up to 125% of the maximum per attached schedule, pages i and 1. For those facilities using more than the maximum rental per schedule, a copy of the lease must be submitted. All transactions entered into after 1/1/71 are subject to the attached schedule pg. 1.

10. Balance Sheet

A copy of the facility's balance sheet, for the period corresponding with the period reported on Schedule B, must be attached. If real property expenses of a related lessor are reported on Exhibit V, the balance sheet of the related lessor must also be submitted.

11. Depreciation

Depreciation is not to be computed on appraisal values. Facilities reporting depreciation must submit a detailed schedule of depreciation. Date of acquisition, cost, salvage value, basis for computing depreciation, accumulated depreciation at start of year, rate and amount must be reported for each asset depreciated. Depreciation is allowable on the straight line method only. The following are suggested guidelines for straight line depreciation.

ITEM	USEFUL LIFE
Real Property	
Buildings - current	40
- built prior to 1960	25
Building Improvements - current	40
- prior to 1960	25
- required to meet fire safety code	10
Land Improvements	
General	20
Paving - asphalt	10
- concrete	15

ITEM	USEFUL LIFE
Shrubs, Trees	10
Fixed Equipment (i.e., elevators, heating, ventilating, air conditioning, boilers, etc.)	20
Medical Equipment	10
Office Furniture and Equipment	10
Autos, Trucks, Ambulances	4

Depreciation on Real Property is reported on Exhibit V. Depreciation on Building Improvements which did not add to the bed capacity is reported on Exhibit IV. All other depreciation is recorded on Exhibit I.

Governmental or Voluntary Facilities with unidentifiable assets may use 2% of total allowable operating expenses (Schedule B, line 7, column 4), less "rental of equipment" (Schedule B, line 4 (d), column 4), in lieu of depreciation. Capital expenditures must not be included in repairs. (Schedule B, line 4 b, column 4).

We urge all Governmental and Voluntary Facilities to maintain depreciation records. The allowance of 2% in lieu of depreciation will be decreased to 1% next year. The 1977 cost study will have no allowance in lieu of depreciation.

INSTRUCTIONS FOR USING MAXIMUM RENT AND IMPUTED RENT ALLOWANCE SCHEDULE (Page L)

1. This schedule does not apply to voluntary or governmental facilities.

2. Column (a) is the maximum rental allowance per bed (exclusive of real estate taxes) for unrelated transactions within Group I areas (Urban).

3. Column (b) is the imputed rental allowance and maximum rental allowance per bed which may be used by controlled corporations within Group I areas (Urban).

4. Column (c) is the maximum rental allowance per bed (exclusive of real estate taxes) for unrelated transactions within Group II areas (Rural).

5. Column (d) is the imputed rental allowance and maximum rental allowance per bed which may be used by controlled corporations within Group II areas (Rural).

6. Maximum unrelated rental allowance Columns (a) and (c) will be used for all transactions entered into after January 1, 1971. However, for leases negotiated prior to this date, the actual lease fee will be accepted up to 125% of maximum.

7. The facility may elect to use the imputed rental allowance plus depreciation on building improvements which did not add to bed capacity, Exhibit IV, in lieu of the following actual real property expenses as reported on Exhibit V: (Exclusive of Real Estate Taxes)

   a. Depreciation on real property.

   b. Interest on mortgage.

   c. Insurance on real property.

   d. Return on equity.

   Use the year original construction was completed to determine the appropriate rate per bed for calculating the imputed rental. Where a new wing or addition has been added to the original building, the imputed rental should be calculated separately; however, amounts for additions are subject to Bureau review and approval.

   Facilities electing to use the imputed rental allowance are not entitled to the expenses listed above (a-d). However, they are entitled to depreciation on building improvements which did not add to bed capacity, Exhibit IV, line 7 and Real Estate Taxes, Schedule B, line 5, b.

ALLOWANCES FOR ADMINISTRATOR SALARIES

BEDS	INDIVIDUAL (I)	TOTAL (II)	BEDS	INDIVIDUAL (I)	TOTAL (II)
1-15	$10,500		130	$24,000	$31,700
20	11,000		140	24,500	33,100
25	11,500		150	25,000	34,500
30	12,000		160	25,500	35,900
35	12,500		170	26,000	37,300
40	13,000		180	26,500	38,700
45	14,000		190	27,000	40,100
50	15,000		200	27,500	41,500
55	16,000		210	28,000	42,900
60	17,000		220	28,500	44,300
65	18,000		230	29,000	45,700
70	19,000*		240	29,500	47,100
75	20,000	$20,500	250	30,000	48,500
80	20,500	21,900	260	30,500	49,900
85	21,000	23,300	270	31,000	51,300
90	21,500	24,700	280	31,500	52,700
95	22,000	26,100	290	32,000	54,100
100	22,500	27,500	300	32,500	55,500
110	23,000	28,900	310	32,750	56,000
120	23,500	30,300	320	33,000	56,500

To determine the administrative salary allowance for facilities with capacities not listed above, add the amount shown in the following schedule for each bed in excess of the next lower bed capacity.

	Column 1	Column II
16-39 Beds	$100	
41-74 Beds	200	
76-99 Beds	100	$280
101-299 Beds	50	140
301 & Over	25	50

*For facilities with less than 75 beds, the amount shown in Column I is the maximum amount allowable as administrator allowances; however, where the owner performs a full tour of duty as a registered nurse, in addition to serving as administrator, an allowance of $100 per bed may be taken under administrator salary, Exhibit I, as well as the reasonable salary as a registered nurse. In these instances no further allowance will be allowed for administrative salaries. In facilities of 75 beds or more, if such allowance is claimed in addition to an administrator, the administrators salary and owners allowance will be subject to the schedule maximum. These allowances will be subject to applicable administrator licensing regulations.

When a salary is being claimed as a registered nurse together with the administrator allowance, Schedule A, question i, should so indicate.

This schedule represents the maximum salaries allowable for administrators and assistant administrators whether owners or employees. In those instances where there are assistant administrators, the salary of the administrator is limited to the amount in Column I.

Where administrator, assistant administrator or owner is affiliated with two or more nursing homes, see Computation of Administrator salaries. (Exhibit III)

DATE OF CONST.	MAXIMUM RENTAL ALLOWABLE UNRELATED LEASES (a)	IMPUTED RENTAL ALLOWABLE and MAXIMUM RENTAL ALLOW. RELATED LEASES (b)	MAXIMUM RENTAL ALLOWABLE UNRELATED LEASES (c)	IMPUTED RENTAL ALLOWABLE and MAXIMUM RENTAL ALLOW. RELATED LEASES (d)
1974	1715	1543	1543	1389
1973	1618	1456	1456	1310
1972	1526	1374	1374	1236
1971	1440	1296	1296	1166
1970	1280	1152	1152	1037
1969	1120	1008	1008	907
1968	1040	936	936	842
1967	960	864	864	778
1966	920	828	828	745
1965	880	792	792	713
1964	840	756	756	680
1963	800	720	720	648
1962	768	691	691	622
1961	736	662	662	596
1960	704	634	634	571
1959	672	605	605	545
1958	640	576	576	518
1957	624	562	562	506
1956	608	547	547	492
1955	592	533	533	480
1954	576	518	518	466
1953	560	504	504	454
1952	544	490	490	441
1951	528	475	475	428
1950	512	461	461	415
1949	496	446	446	401
1948	480	432	432	389
1947	464	418	418	376
1946	448	403	403	363
1945	432	389	389	350
1944	416	374	374	337
1943	400	360	360	324
1942	384	346	346	311
1941	368	331	331	298
1940	352	317	317	285
1939	336	302	302	272
1938	320	288	288	259
1937	304	274	274	247
1936	288	259	259	233
1935	272	245	245	221
1934	256	230	230	207

URBAN - GROUP I AREAS

1	Atlantic City	11	Mercer
2	Bergen	12	Middlesex
3	Burlington	13	Monmouth
4	Camden	14	Morris
7	Essex	16	Passaic
9	Hudson	20	Union

RURAL - GROUP II AREAS

1	Atlantic	15	Ocean
5	Cape May	17	Salem
6	Cumberland	18	Somerset
8	Gloucester	19	Sussex
10	Hunterdon	21	Warren

State of New Jersey
Department of Institutions and Agencies
Division of Medical Assistance and Health Services
1975

COST STUDY FOR LONG TERM CARE FACILITY SCHEDULES AND EXHIBITS

Certification

I _____ _____
Name (Print or Type) Title

of _____ _____
Name of Long Term Care Facility County

_____, _____, _____, _____
Address City State Zip Code

do certify that the contents of the financial statements and related data contained in this report have been reviewed by me and are, to the best of my knowledge and belief, true and correct and have been carefully prepared from the official records of this institution. Our latest natural fiscal year was _____, 19_____ to _____, 19_____.

_____ _____
Signature of Owner, Partner or Officer Signature of Preparer

_____ 19_____ _____ 19_____
Date Mailed Date Prepared

_____ (_____) _____
Area Code & Telephone Number of Nursing Facility Area Code and Telephone Number of Preparer

GENERAL AND STATISTICAL INFORMATION

Schedule A, Page 1

(check all blocks applicable)

a. Type of Facility

_____ Hospital
_____ Long Term Care Facility
_____ Skilled # _ _ _ _ _
_____ ICFA # _ _ _ _ 7
_____ ICFB # _ _ _ _ 8
_____ Nursing Unit in Home for Aged
_____ Residential Unit
_____ Public Medical Institution
_____ Other _____
Specify

b. Type of Ownership

_____ Proprietary
_____ Proprietorship
_____ Partnership
_____ Sub-Chapter "S" Corp.
_____ Corporation
_____ Voluntary
_____ Other _____
Specify
_____ Governmental

Provider #_____ Schedule A, Cont'd.

c. If more than one block is checked under type of facility, attach a statement explaining which expenses have been allocated between the long term care section and other sections, and the basis of allocation.

d. The period covered by the most recent audit of our financial records by an independent public accountant was from _____19_____to_____ 19_____, by

_____ _____ _____
Name of Firm Address Zip Code

( )
_____
Area Code and Telephone Number

Please submit a copy of the above audit report with your completed Cost Study.

Facilities having records maintained by outside sources must indicate location of records:

_____
_____
_____

Is facility unionized? Yes_____ No_____

If yes: Name of Union_____ Dates of Contract_____

e. Is the administrator, assistant administrator, owner or officer associated with any other Medicaid facility in New Jersey?
Yes_____ No_____
If yes, complete below:

Name of Individual	Facility Associated With	Medicaid Provider No.	No. of Beds	Primary Duty	Salary
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____

f. Were any owners/officers or members of their families living on nursing facility grounds?
Yes_____ No_____ If yes, complete below:

Name	Expenses Apportioned	Amounts Apportioned
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____

Provider #_____ Schedule A Cont'd

Explain basis for apportionment on separate schedule. Apportioned expenses should be deducted on Exhibit II Page 13.

g. Were any members of the owners/officers' families on the payroll or recipients of any monies for special services? Yes_____No_____. If yes complete below:

Name	Services Performed	Hours Worked	Salary or fee Paid
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____

h. Were services purchased or rentals and leases arranged involving organizations related by common ownership or control for any of the following expense categories?

	Yes	No		Yes	No
1. Administrator	____	____	5. Housekeeping	____	____
2. Rental of Facilities	____	____	6. Maintenance	____	____
3. Dietary	____	____	7. Accounting Fee	____	____
4. Laundry	____	____	8. Other (Specify)	____	____

If the answer to any of the above is Yes, please attach a statement containing the pertinent details of agreement.

i. List below all owners or officers for whom salaries or drawings have been included as allowable expense in Schedule B of the Cost Study Page 7.

Name of Owner	Primary Duty	Hours Per Week	Amount included as an allowable expense			
			Federal Form 941	Per 1099	Other	Unpaid (Attach Statement)

Provider #_____ Schedule A Cont'd.

j. Patient Days - Long Term Care Facility _____.

*Daily Semi-Private Room Rate, at date of preparation as defined in Skilled Nursing Home Service Manual - Paragraph - 202.1

Actual Patient Days From____19__to_____19_____ (Must be same period covered by Sch. B and question 7 below)

		Minimum*	Maximum*	Skilled	ICFA	ICFB	Total
1.	Private	$_____	$_____	_____	_____	_____	_____
2.	Medicaid	_____	_____	_____	_____	_____	_____
3.	Medicare	_____	_____	_____	_____	_____	_____
4.	Other____ Specify	_____	_____	_____	_____	_____	_____
5.	Total	xxxxxxxxxxxxxxxxxx		_____			
6.	Number of Medicaid Patients as of December 31, 1974.			_____			

		# of Beds (Include Quiet Room)	# of Days in period	Maximum Bed Days
7.	Maximum Bed Days(**)	_____	_____	_____
8.	Actual Patient Days (j5)			_____
9.	% of Occupancy (j8÷j7)			_____%
10.	80% of j7 if j9 is below 80%			_____days
11.	95% of j7 if j9 is above 95%			_____days

**If there has been a change in certified bed capacity during the reporting period, complete as in the following example:

	Beds		Days	Maximum Bed Days
July 1 to September 30	200	x	92	18,400
October 1 to June 30	250	x	273	68,250
	XXX		365	86,650

k. Date of Construction of Facility

			Year	#of Beds	Cost
1.	Construction of Building Completed (Not when acquired)		_____	_____	_____
2.	Building additions New Construction-Adding Beds	a.	_____	_____	_____
		b.	_____	_____	_____
		c.	_____	_____	_____

Provider #_____ Schedule A Cont'd.

3. Has there been a change in operations or ownership during the year?
No_____Yes_____Explain_____

_____

_____

_____

1. The Cost Study Statements are prepared on the following basis:

(1) _____ (2) _____ (3) _____
Accrual Cash Other (Explain)

m. Please list name and salaries of all salaried Physicians, Tharapists, and Pharmacists on Staff (Do not include personnel on a Fee basis)

Name	Gross Salaries Paid Per 941	Per 1099
1.		
2.		
3.		
4.		
5.		

n. Please explain the method used by your facility in the handling of oxygen expenses for Medicaid recipients. Attach separate sheet if needed.

_____

_____

_____

_____

Statement of Operations

Period _____ 19____ _____ 19____
From To

Latest 12 month period required. If less than 12 months, attach explanation. Period Must Agree with that used in Schedule A Page 4 question j7.

a. Income (OMIT CENTS) (*)

	Amount Skilled	ICFA	ICFB	Total
1. Room, Board and Routine Care				
a. Private				
b. Medicaid				
c. Medicare				
d. Other (specify)				
Total				

2. Other Income from Patients	Medicaid	Medicare	Private
a. Telephone			
b. Laundry	XXX	XXX	
c. Dry Cleaning			
d. Private Nursing Service	XXX		
e. Prescribed Drugs	XXX	XXX	
f. Laboratory	XXX	XXX	
g. Hand Feeding	XXX	XXX	
h. Therapy	XXX	XXX	
I. Medical Supplies	XXX	XXX	
j. Incontinency	XXX		
k. Television			
l. Other (attach list)			
Total			

3. Miscellaneous Income	
a. Meals sold to Guests or Employees	
b. Room Rented to Employees	
c. Laundry Service to Employees	
d. Services and Supplies sold to Employees	
e. Telephone Commissions	
f. Purchase Discounts and Rebates	
g. Property and Equipment Rentals	
h. Contributions	
i. Interest	
j. Vending Machines	
k. Gift Shop and Snack Bar	
l. Barber Shop and Beauty Shop	
m. Other (attach list)_____	
Total	

Total Gross Income (1+2+3) _____

(*) Report all income as recorded in your books of account. Income items which are reduction of expenses should be indicated on Exhibit II. Page 13.

Provider Number_____ Schedule B, Cont'd

Statement of Operations (Cont'd)

b. Expenses	Number of Employees		(1) Expenses Per Records	(2)	(3) Less Income Offsets &Non Allow. Exp. Per Exh. II	(4) (1&2-3) Expense Claimed
	Part Time	Full Time	Salaries	Non Salaries		
1. Admin. & Gen. (Exhibit I)						
2. Room and Board						
a. Dietary other than food						
b. Food	XX	XX	XXX			
c. Laundry						
d. Housekeeping						
Total Room and Board						
3. Health Care						
a. Registered Nurses						
b. L.P.N.'s						
c. Aides and Ward Clerks						
d. Med. Supplies (do not include drugs)	XX	XX	XXX			
e. Physicians						XXX
f. Pharmacy & Drugs						XXX
g. Laboratory & X-ray						XXX
h. Recreational Therapy						
i. Physical-Speech,Hearing, and Occupational Therapy						XXX
j. Out-Patient Clinic						
k. Oxygen						
l. Other (att. list)						
Total Health Care						
4. Plant Operations						
a. Salaries						
b. Repairs (Not capitalized)	XX	XX	XXX			
c. Utilities	XX	XX	XXX			
d. Equip. Rental	XX	XX	XXX			
e. Supplies	XX	XX	XXX			
Total Plant Oper.						

Provider Number_____ Schedule B

Statement of Operations (Cont'd)

	Number of employees		(1) Expenses per Records	(2)	(3)	(4)
	Part Time	Full Time	Salaries	Non Salaries	Less Income Offsets &Non Allow. Exp. Per Exh. II	(1&2-3) Expense Claimed
5. Property Expense						
a. Rent of Bldgs. Exh. VI	XX	XX	XXX			
b. Real Estate Taxes	XX	XX	XXX			
c. Ins. on Real Prop. (Note III)	XX	XX	XXX			
d. Imputed Rent Exh. IV	XX	XX	XXX			
e. Real prop. expense & return on Equity Exh. V	XX	XX	XXX			
f. Total Property Expense	XX	XX	XXX			
Misc. Expense						
6. Non-allowable						
a. Gift Shop and Snack Bar						XXX
b. Barber and Beauty Shop						XXX
c. Social Service Dept.						XXX
d. Contributions	XX	XX	XXX			XXX
e. Income Taxes	XX	XX	XXX			XXX
f. Bad Debts	XX	XX	XXX			XXX
g. Other (attach list)						
Total Misc. Expense						
7. Total Expenses (1+2+3+4+5+6)						
8. 2% of line 7, Column 4 (in lieu of depreciation) for Voluntary and Governmental Homes with unidentifiable assets						
9. Total expenses (7+8)						

(Note I) (Note II)

Provider Number_____ Schedule B, Cont'd.

Statement of Operations (Cont'd)

Note I Must be reconciled to Schedule B-1.

Note II Must agree with Exhibit II.

Note III Facilities electing to use imputed rental may not use insurance expense.

Provider No. _____ Schedule B-1

Reconciliation of Gross Salaries

Salaries Per Forms 941 (attached)

Quarter ended	Amount	
_____	_____	
_____	_____	
_____	_____	
_____	_____	_____

Salaries Per Forms 1099

Name	Amount	
_____	_____	
_____	_____	
_____	_____	
_____	_____	_____

Earnings of Partners or Stockholders in Subchapter S corporations

Name	Amount	
_____	_____	
_____	_____	
_____	_____	
_____	_____	_____

Total paid during period		_____
Less accrued salaries beginning of period	-	_____
Plus accrued salaries end of period	+	_____
Total Salaries Schedule B, Column 1, line 9, Page 8		_____

Provider No._____ Exhibit I

Administrative and General Expenses

a. **Salaries** Omit Cents

1.	Owners/Officers_____		$_____	
2.	Admin. - (Name)_____	Lic. #_____	$_____	
3.	Ass't. - (Name)_____	Lic. #_____	$_____	$_____ (1)
4.	Other Office Personnel			
	a. Full Time #_____		$_____	
	b. Part Time #_____		$_____	$_____
				$_____

b. **Taxes**(2)

1.	Social Security Tax Expense (Employer's share)	$_____	
2.	State and Federal Unemployment Tax	_____	
3.	N.J. Business Personal Property Tax	_____	
4.	N.J. Corporate Business Tax (3)	_____	
5.	Other (attach list)	_____	
	Total Taxes		$_____

c. **Insurance** (Include Real Property Insurance on Exh. V)

1.	Personal Property	$_____	
2.	Employees Life, Health, Etc.	_____	
3.	Employees Pension Plan	_____	
4.	Workmen's Compensation	_____	
5.	Malpractice	_____	
6.	Other (attach list)	_____	
	Total Insurance		$_____

d. **Other**

1.	Interest (other than mortgage) (attach schedule)	$_____	
2.	Depreciation (see instructions pg. h)	_____	
3.	Office Supplies and Expense	_____	
4.	Postage	_____	
5.	Association Dues	_____	
6.	Telephone (Exclude directory advertising on Exhibit II)	_____	
7.	Advertising (Exclude all but recruitment and bold print Yellow Page ads on Exhibit II	_____	
8.	Travel	_____	
9.	Legal Fees	_____	
10.	Accounting Fees	_____	
11.	Miscellaneous (attach list)	_____	
	Total Other Expenses		$_____
	Total (b+c+d)		$_____
	Total (a+b+c+d)		$_____

(1) Administrator and Assistant Administrator Salaries in excess of maximum, per schedule in instructions, must be shown as non-allowable in Exhibit II.

(2) Exclude Income and Real Estate Taxes, enter Real Estate Taxes on Page 8, Schedule B, Line 5b.

(3) Exclude tax on income on Exhibit II

Provider No._____ Exhibit II

Income Offsets and Non-Allowable Expenses
(This Exhibit Must be completed)

1. Income Offsets (Omit cents)

2. Non-allowable Expenses (Omit Cents)

	(1) Salaries	(2) Non Salaries	(3) Total	(4) *
a. Telephone charges	XXX			
b. Private Nursing Service				
c. Interest on Unrestricted Investments (to the extent of other Int. Exp.)	XXX			
d. Receipts from Employees for Goods or Services	XXX			
e. Purchase Discounts	XXX			
f. Property or Equip. Rentals	XXX			
g. Items sold for use outside tha Med. Facility	XXX			
h. Other (attach list)				
Total Income Offsets (a to h)				
a. Non-Working Officers' Salaries		XXX		
b. Promotion and Fund Raising				
c. Travel and Entertainment Other than for professional meetings, etc.	XXX			
d. Contributions	XXX			
e. Income Taxes	XXX			
f. Pharmacy and Drugs - (List Salaries in Schedule A, m.)				
g. Barber & Beauty Shop				
h. Snack Bar & Gift Shop				
i. Social Services				
j. Advertising (other than recruitment and bold print)	XXX			
k. Interest to owners & related lenders	XXX			
l. Bad debt expense	XXX			
m. Research				
n. Physicians (list in Sch. A,m.				
o. Therapists' (List in SchA,m.				
p. Dep'n. in excess of straightline (Note a)	XXX			
q. Administrators' salaries in excess of schedule		XXX		

Income Offsets and Non-Allowable Expenses Cont'd.

	(1) Salaries	(2) Non Salaries	(3) Total	(4) *
r. Value of meals served to Owners				
s. Value of owners' residency (Sch. A.F.)				
t. N.J. Corporate Business Tax (income amount)	XXX			
u. Laboratory and X-ray				
v. Legal fees not for N.F. operation				
w. Amortization of Pre-operating costs on organization expense	XXX			
x. Other (attach list)				
Total Non-Allowable Expenses (A to X)				
Grand Totals (1&2)			Transfer to Schedule B	

* Indicate line in Schedule B where amounts are deducted (Note a) No adjustment is needed if depreciation is reported on Exhibit I and V at the straight line amount.

PROVIDER NO. _____ EXHIBIT III

COMPUTATION OF ALLOWABLE ADMINISTRATORS' SALARIES

(To be completed by Related Facilities)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Medicaid Provider Number	Name of Facility	Name	Name	Name	Name	Name	Name	Total
	Other activities or non-participating fac.							

(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)
Medicaid Provider Number	Name of Facility	No. of Beds	Amounts Allowable Col. (I)	Amounts Allowable Col. (II)	Difference	%	Maximum Allowable	Actually Paid	Adjustment

Provider No._____ Exhibit IV

Imputed Rental Computation

(To be completed by Proprietary Nursing facilities participating in related rentals or those not renting their facilities)

1. Check Appropriate Area (1) Urban_____ Rural_____

	Group I			Group II	
	Year Construction Completed	Number of Beds	Rate (2)	Amount	Code (3)
2. Original Construction	_____	_____	_____	$_____	_____
3. New Construction*	_____	_____	_____	_____	_____
4. New Construction*	_____	_____	_____	_____	_____
5. New Construction*	_____	_____	_____	_____	_____
6. Total Imputed Rental				_____	
7. Depreciation on Building Improvements which did not increase bed capacity				_____	
8. Total Imputed Rental and Depreciation on Building Improvements				$_____	

Important

Compare line 8, Exhibit IV with line 2j, Exhibit V, and transfer only the larger of the two amounts to Schedule B (5d) or (5e) as appropriate.

(1) Refer to instructions for counties included in Group I or Group II areas (page 1).

(2) Refer to instructions for the rate to be used in your county for the year that construction was completed (page 1).

(3) Indicate:
- (a) Self contained addition including separate kitchen and heating facilities.
- (b) Addition of rooms only, utilizing original kitchen and heating facilities.
- (c) Other (attach explanation).

(4) Real Estate Taxes are not included in Imputed Rental Calculation, they may be reported in addition to Imputed Rentals on Schedule B line 5 (b).

* Only additions increasing Bed Capacity considered here, not improvements.

Provider No. _____ Exhibit V

Real Property Expenses Including Return on Equity

(To be completed by Proprietary Nursing Facilities Not Renting or with related lease contracts and all Voluntary and Governmental Nursing Facilities)

1. Real Property Expenses (OMIT CENTS)

a.	Mortgage Interest (1) _____ %	_____
b.	Depreciation on Real Property (see instructions pg. h)	_____
c.	Insurance on Nursing Facility Buildings	_____
d.	Total Real Property Expenses	_____

2. Equity Computation (Proprietary Facilities Only)

		Beginning of year	End of year	Year Average	
a.	Real Property Costs*	_____	_____	_____	
b.	Land Costs*	_____	_____	_____	
c.	Total (a. + b.)	_____	_____	_____	_____
	Less:				
d.	Mortgage Payable	_____	_____	_____	
e.	Notes Payable (1)	_____	_____	_____	
f.	Accum. Dep'n.	_____	_____	_____	
g.	Total (d.+e.+f.)	_____	_____	_____	_____
h.	Net Average Equity (2c - 2g)				_____
i.	Return on Equity 10 1/2% of line h.				_____
j.	Total real property expense and return on equity (1d+2i)				_____

Important

Compare line 2j, Exhibit V with line 8, Exhibit IV and transfer only the larger of the two amounts to Schedule B, (5e) or (5d) as appropria

For notes used to finance real property negotiated with a lender not related through control, ownership, affiliation or personal relationsh to borrower, include the interest thereon in item (1a) above and the principal in item (2e).

*Appraisal values must not be used in calculating equity, these costs should be for nursing facility property only. Where records of controlled lessor are used for Equity Computation (Proprietary Facilities Only) separate Balance Sheets must be attached to support items entered.

Is lessor related by common ownership or control with lessee? Yes____ No____. If yes attach explanation and enter real property expenses of nursing home as shown on lessor's books in Exhibit V .

Building Rental

(To be completed by nursing facilities with unrelated leases only)

1. _____ (Name of Lessor) _____ (Address) ( ) _____ (Area Code-Telephone No.)

2. Period of Lease _____ 19___ (From) _____ 19___. (To)

3. Annual Gross Rental Fee (per lease contract) $_____
   Less the following if included in gross rental:

4. Rental of movable equipment $_____

5. Real Estate Taxes _____

6. Building Insurance _____

7. Utilities _____

8. Other Expenses (attach list) _____

9. Total (4+5+6+7+8) $_____ (1

10. Net Building Rental (3-9) _____ (1

11. Building Rental Allowable (Unrelated Rates Only)
    Check Appropriate Area (2) Group I_____ Group II_____.

	Year Const. Completed	# of Beds	Rate (3)	Amount
12.				$
13.				
14.				
15.	Total			$

16. 125% of line 15 for unrelated transactions entered into prior to 1/1/71. (attach copy of lease) $_____

17. Building rental allowable (larger of 15 or 16). Enter on Schedule B the smaller of line 10 or 17. $_____

Notes: (1) Include these expenses separately in Schedule B.
(2) Refer to instructions for counties included in rural and urban areas (page i).
(3) Refer to instructions for rate to be used in your county for the year that construction was completed (page i).

	Date of Inspection	Defi-ciencies	Life Safety	Certi-fication	Date	No Change	Problems
SHBROOK	6-5-74	22	5	No			
LLENDALE Allendale	11-14-73	19	5	No			Nursing Dietary Social Service
MBOY Perth Amboy	4-18-74	17	0	Yes	9-9-74	5	Dietary
NDOVER Andover	11-8-73	23	7	No			Nursing Dietary Social Service
RNOLD WALTER	3-11-74	6	4	Yes	6-27-74	0	
AYVIEW BAYVILLE	9-5-73	17	9	No			Physicians Nursing
EACHVIEW	1-29-74	7	1	No	10-1-74	4	
ARN HILL NEWTON	1-29-74	33	5	No	8-26-74	10	Physicians Dietary Nursing
ELLEVUE	3-26-74	4	4	Yes	7-24-74	0	
ERGEN PINES PARAMUS	6-13-74	20	17	No			Physicians Nursing Dietary
IRCHWOOD	12-10-73	11	8	Yes	4-22-74	0	*New Deficiencies

	Date of Inspection	Deficiencies	Life Safety	Post Certification	Date	No Change	Problems
RIDGETON BRIDGETON	12-3-73	20	6	No			Physicians Social Service
RUNSWICK NEW BRUNSWICK	4-26-74	18	3	Yes	7-23-74	8	Physicians Nursing Social Service Dietary
INNAMINSON	12-7-73	6	10	No			
LAREMONT POINT PLEASANT	5-6-74	16	4	No			Physicians Nursing Social Service Dietary
HESTNUT HILL PASSAIC	8-13-74	20	3	Yes	10-9-74	3	
LIFF HOUSE ENGLEWOOD	12-11-73	44	11	No	11-12-74	3	Physicians Nursing Dietary Social Service
ONV-A-CENTER	3-25-74	3	3	Yes	6-4-74	0	
OOPER RIVER	3-5-74	10	2	Yes	5-23-74	0	
ORNELL	9-25-74	17	2	No			Social Service Nursing
RANFORD	12-18-74	17	4	No			Dietary Nursing Social Service Physicians Housekeeping-Dirt
RESTVIEW MARLTON	10-17-73	22	11	No			Nursing Dietary Housekeeping

	Date of Inspection	Deficiencies	Life Safety	Post Certification	Date	No Change	Problems
UGHTERS OF ISRAEL EAST ORANGE	9-25-73	23	7	No			Physicians Social Service Dietary Housekeeping
UGHTERS OF MIRIAM	8-9-73	9	9	No			
LLRIDGE PARAMUS	11-8-73	25	4	No			Physicians Social Service Nursing
VER	2-13-74	8	1	Yes	8-12-74	0	
NROVEN	4-9-74	10	4	No			
ST ORANGE	6-17-74	46	1	No			Physicians Social Service Dietary
TENDED	5-15-74	24	4	No			
IZABETH	8-20-74	25	13	No			
DISON EDISON	6-27-74	41	2	No	10-16-74	16	Housekeeping Physicians Dietary
NING	1-9-74	2	8	Yes	5-30-74	0	

	Date of Inspection	Deficiencies	Life Safety	Post Certification	Date	No Change	Problems
IERY MATAWAN	11-1-73	16	7	No			Social Service
'ERGREEN	11-16-73	1	4	No			
ANKLIN	6-24-74	37	3	No			
ENSIDE NEW PROVIDENCE	9-7-73	33	2	No			Social Service Physicians Nursing Dietary
OLDEN CREST	12-10-73	8	8	No			
REEHOLD	8-22-74	2					
REENBRIAR	12-27-73	7	12	No			
REENBROOK GREENBROOK, N.J.	6-3-74	23	0	No	10-7-74	8	Physicians Nursing
REENFIELD SOMERVILLE	6-27-74	36	1	No	10-21-74	4	Housekeeping Physicians Social Service
ARTWYCK PLAINFIELD	5-1-74	20	2	Yes	8-5-74	10	Physicians Nursing
ARTWYCK W.	7-24-74	9	2	No			

	Date of Inspection	Defi-ciencies	Life Safety	Certi-fication	Date	No Change	Problems
LLY MANOR	5-14-74	37	6				
ATH VILLAGE	5-28-74	20	2	No			Housekeeping Nursing Physicians
CARE HERITAGE HALL NEW SHREWSBURY	10-4-73	18	11	Yes	1-30-74	7	Nursing Housekeeping
LLCREST	3-12-74	14	4	Yes	5-8-74	0	
LL TOP	1-24-74	12	7	Yes	7-3-74	0	
LMDEL HOLMDEL	5-17-74	19	5	No			Dietary Physicians Housekeeping Nursing
DSON	1-29-74	8	4	Yes	8-12-74	4	
GLENMOOR	5-9-74	36	4	No			
WISH GERIATRIC	9-21-73	2	0	No			
RC BERGEN COUNTY	4-18-74	7	2		7-18-74	0	
RC N.J. JERSEY CITY	5-30-74	14	1	Yes	7-15-74	6	Dietary Nursing Housekeeping
IN MONTGOMERY	3-20-73	4	6	Yes	7-2-74	1	

	Date of Inspection	Deficiencies	Life Safety	Certification	Date	No Change	Problems
ANOR CARE					5/8/74	0	physicians; dietary
ANOR (Penalty)	5/22/74	22	6	Yes	9/25/74	8	physicians; dietary
APLE SHADE	3/28/74	9	3	Yes	5/2/74	0	
ADOW LAKES	7/23/74	7	1	No			
DFORD	11/12/73	6	4	No			
DICENTER eptune)	11/29/73	10	6	No			
DICENTER ed Bank)	3/14/74	5	0	Yes	6/20/74	0	
RCER CARE	1/8/74	1	5	Yes	4/9/74	2	phone
RCERVILLE	1/21/74	7	5	Yes	6/19/74	5	physicians & nurs
RRY HEART	7/11/74	35	0	Yes	10/10/74	14	nurses, physician physical dietary
RWICK	6/20/74	6	7	Yes	6/20/74	6	
NMOUTH	11/19/73	20	16	Yes	2/28/74	2	physicians
RRIS HALL	6/25/74	7	1	No			
ORESTOWN	11/16/73	5	7	No			

	Date of Inspection	Defi-ciencies	Life Safety	Certifi-cation	Date	No Change	Problems
STOWN					6/25/74	13	dietary; nursing; physical environment
HOLLY	12/5/73	0	1	No			
LAUREL	4/18/74	20	4	Yes	8/7/74 11/4/74	0	physical therapist; dietary
FIELD		12	10				
JERSEY	5/3/74	31	5	Yes	9/25/74	5	physicians; medicatio
INK	6/13/74	13	5	Yes	8/1/74	1	dentist
K HEALTH	1/3/74	20	3				physicians; medicatio nursing; dietary
EW	2/14/74	12	3	Yes	8/8/74		
GROVE	11/1/74	16	4				
OOK	12/21/73	10	1				
POINT	7/17/74	16	10				dietary; housekeeping medication; physician nursing
ADY	4/29/74	3	1				
ADE		18	11				speech therapist,phys medication; nursing
ACRES	1/8/74	28	7				nursing; dietary; soc service

	Date of Inspection	Deficiencies	Life Safety	Verification	Date	Change	Problems
WOOD	11/12/73	8	17				physical
CETON	9/30/74	11	12				physician, nursing and rehabilitative service pharmaceutical, dental social services; patie activities; physical environment
BOW	5/14/74	11	5	Yes	8/21/74	0	
TAN	10/19/73	44	2				
EVELT	4/10/74	15	1				
MARY'S					8/8/74		
M	7/10/74	13	10	Yes	10/9/74	3	
LED		4	1				
TOR	5/16/74	10	1				
TFORD	4/16/74	4	1	Yes	7/1/74	0	
EN'S	5/17/74	10	4	Yes	8/28/74	6	dietary; pharmaceuti

Statement of

Herbert Semmel

Center for Law and Social Policy

Washington, D.C.

on behalf of the

National Council of Senior Citizens

Presented to the

New Jersey Nursing Home

Investigation Commission

May 2, 1975

I wish to express my appreciation and that of the National Council of Senior Citizens for the invitation to appear before this Commission. I am an attorney with the Center for Law and Social Policy. The Center is a public interest law firm located in Washington, D.C. Among the major areas of activity of the Center is our health law project, designed to represent consumer interests in the provision of health services, to increase the availability and to improve the quality of health care.

The National Council of Senior Citizens is the largest organization of older people and older people's clubs in the nation. The Council has 3,000 member clubs through which three million members are affiliated with the National Council. New Jersey has the largest membership in the National Council of any state. The National Council has a special interest in health care problems because health is such a major factor in the lives of older people. Indeed, the National Council of Senior Citizens was originally formed to support a national program of health care for the aged, now known as Medicare.

The Center for Law and Social Policy was asked by the National Council of Senior Citizens to review the process of regulation of nursing homes in light of the terrible and tragic conditions found in so many nursing homes despite the lengthy roll of laws and regulations, federal and state. The Center has conducted an eight-month study of regulatory

processes in several states. We were fortunate to learn that a similar study was underway by the New Jersey Office of Public Advocate and have joined with them in developing a new regulatory program. We believe this program offers the opportunity to improve nursing home conditions and reduce unnecessary governmental expenditures by removing the profit from non-compliance with laws and regulations.

I am not going to take the time today to recite for you what the U.S.-Senate Committee on Aging has accurately titled "The Litany of Nursing Home Abuses." There have been numerous investigations, official reports and newspaper exposes in the past fifteen years. Despite the constant stream of public information about the poor level of care, the unsanitary conditions and the inhuman treatment of patients, nothing seems to be changing. It is shocking, but not surprising, that the Senate Committee on Aging, after extensive research, made a conservative estimate that at least half the homes are substandard. The situation in New Jersey is no better than that prevailing nationally. I have reviewed more than one hundred inspection reports made by the New Jersey Department of Health. These are the results of pre-announced inspections, when the homes are at their Sunday best. The reports tell the story of massive failure to abide by the minimum standards set out in laws and regulations. Perhaps the

most damning indictment comes from the nursing home industry itself. The industry's proprietary trade association, the American Nursing Home Association, recently changed its name to the American Health Care Association. A major reason given the change was "the generally pejorative connotation of the term 'nursing home' in our language."

Nursing homes have indeed become a 'dirty word' in our language, a reflection of the fact that the public, at least in general, understands that much is wrong with the way America cares for its sick, aged population. Conditions have not improved despite this public knowledge, despite the fact that more than one billion dollars annually is poured into the homes through the Medicare and Medicaid programs, and despite the extensive federal and state laws and regulations. What this all means is that there has been a colossal failure of the nursing home industry, of private enterprise and of government.

We have undertaken to examine the causes of this failure and in particular the role of government. Working together with the Office of Public Advocate, we have developed a proposal for a system of regulation which ties reimbursement to quality of care, at least to the limited extent that such quality may be measured and quantified. We simply must end the present system under which homes profit by non-compliance with laws and regulations. Mr. Van Ness has already outlined the substance of the proposal

to you and I will comment on it further in just a moment. We have also submitted to this Committee a detailed memorandum explaining the plan. In addition to this proposal, the National Council of Senior Citizens believes that a series of other changes should be initiated to insure at least the minimal conditions which the sick, elderly people deserve and for which the elderly, their families and the public are already paying.

(1) A properly functioning system of inspections of nursing homes, including

(a) unannounced visits,

(b) bi-monthly inspections,

(c) nighttime inspections, and

(d) proper inspector training.

(2) Development of an alternative system of state reimbursement for health care for the elderly in their homes.

(3) Adoption of a patients' bill of rights and institutionalization of the enforcement of these rights through a nursing home ombudsman office.

(4) Expanded public access to information concerning nursing homes, including direct disclosure of inspection reports to doctors, patients and persons to whom promotional literature is delivered.

(5) Development of state-sponsored, in-service training programs for non-professional nursing home employees having direct patient contact.

Before turning to these issues, I want to touch on a vital matter--the question of money, or, more accurately, the cost of providing adequate care in nursing homes. Decent care cannot be provided cheaply. Any notion about "saving money" by cutting back on expenditures for nursing homes must be understoood in this context--the savings will come out of the hide of the patients. The present maximum rate in New Jersey of $27.60 per diem for skilled nursing homes is the minimum for which proper care can be accomplished at current costs. The latest figures compiled by the Social Security Agency on nursing home reimbursement rates are for 1971. In that year, the average reimbursement to New Jersey nursing homes under Medicare's reasonable cost reimbursement rate was $25.44; the average national rate was $23.60. The average charge made by New Jersey nursing homes to private patients in Medicare-certified homes was $33.95. Since 1971, the consumer price index has risen thirty percent, and health care costs have increased even more sharply. Using the consumer price index, we may project current Medicare reimbursement average per diem at $33.00 and the national average at $30.50. Thus the current rate of $27.60 paid by New Jersey under its Medicaid program is twenty percent below what the Social Security Administration is paying under a reasonable cost formula in New Jersey, and ten percent below even the national Medicare rate.

We are not unmindful of recent revelations of extra-ordinary profits achieved in some nursing homes. Some of

these cases result from New York's virtually unlimited cost reimbursement system, some from the lack of proper safeguards against fraud and some from the absence of an adequate auditing program. But by and large, these extraordinary profits have been stolen from the patients. What I mean is that the homes have been paid a reasonable rate under Medicare and Medicaid for the quality and scope of care promised, but have not delivered. Instead, the owners have pocketed huge profits and the patients have suffered "a litany of abuses"--physical and mental abuse; unsanitary conditions; poor food, poorly prepared; theft of property; excessive use of drugs and degrading physical restraints; assaults on dignity; and reprisals against those who complain.

Our basic proposal seeks to remove the profit from such conditions, from non-compliance with the minimum standards required by law. The present system is absurd. The inspection reports continue to show repeated violations, which means that the nursing homes are not delivering the quality of services contracted for. But the state continues to pay for these substandard services at the full rate. If the state employed a contractor to resurface the highways and the product was highways with cracks and holes, would the state pay for the job in full, let alone continue using the contractor for future resurfacing? Yet that is precisely what is happening with nursing homes.

In the case of the road contractor, the state can at

least discontinue future usage of the contractor. But experience has shown that de-licensing and Medicaid de-certification are simply not practical remedies for general usage with nursing homes. These procedures are too severe; de-licensing puts the home out of business and Medicaid decertification has the same effect for most homes. They would quickly bring about a shortage of beds, given the condition of the majority of homes. The risks of "transplantation shock" are too high to justify movement of patients except in exceptional circumstances and after proper planning. Yet it is this inflexible remedy--closing a home--that is the only regulatory device that is currently perceived as available by the Departments of Health and Institutions and Agencies.

The proposal before you from the National Council of Senior Citizens and the Office of Public Advocate involves the development of a reimbursement formula under which the payment is to reflect the level of compliance with the minimum standards of care set out in federal and state regulation. After allowing some leeway for minor deficiencies, the state would reduce its Medicaid payment in some ratio proportionate to the scope of deficiencies. In weighting various deficiencies, two criteria will prevail--effect on the life and health of the patient and the unreasonable profit (cost reductions) of the home.

A crucial aspect of the proposal is that the Medicaid

payments will be automatically reduced as violations are discovered and likewise automatically increased when the Department of Health determines that the violations have been remedied. The nursing homes will no longer be receiving payments to which they are not entitled, will lose the financial incentive not to comply with the law. Adequate assurances of due process are provided nursing homes by provisions for administrative hearings if they contest the findings of the inspectors. But these hearings will not stay the reduction in payments pending the outcome of the hearings, thus removing the incentive of the home to litigate endlessly and often frivolously.

No single aspect of a regulatory scheme will produce miracles. However, the failure of regulation based primarily on de-licensing and Medicaid decertification is clear. After reviewing alternatives being developed in other states, we believe this graduated payment system holds the most promise to deliver at least compliance with the minimal requirements for decent care prescribed by law.

An Adequate Inspection System

No regulatory system will succeed without a properly functioning inspection system. At present, what exists in New Jersey is next to nothing--an annual preannounced survey of the home. This annual survey does nothing more than comply with the minimum federal requirements. What

are conditions the other 364 days of the year? How are patients treated during the crucial nighttime hours? Are they strapped in their beds, left to lie in their own urine and feces? What is the truth about the food, service, sanitary conditions, recreation, therapy and so many other elements of decent care? Accurate answers to these questions cannot come from preannounced annual surveys for which the nursing homes have weeks to prepare. In addition to the annual survey, bi-monthly unannounced inspections are the minimum necessary. At least half of these should occur between 8 p.m. and midnight. Special security arrangements are needed to prevent leaks of inspection dates, a frequent occurrence in states utilizing unannounced inspections. Revelation by any employee of inspection dates to any operator should be grounds for dismissal. Inspection dates should be randomized, so that operators cannot predict the dates. Inspectors should not be told of inspection schedules until the last possible date.

Although increased inspections will require increased personnel, this should not cause an increase in overall cost. Violations disclosed through inspection will bring about a reduction in reimbursement rates if our proposal is implemented. Indeed, we anticipate that the savings to the state in the immediate future will far outstrip the costs of an adequate inspection program.

Enforcement of Patients' Rights

The necessity for inspectors to personally observe operations in normal conditions is underscored by the difficulty in obtaining information from patients because of their vulnerability to reprisal and their fears of reprisal. Nursing home patients are by definition sick, needing medical and nursing care. They are unable to provide for themselves. Their average age is 82; seventy-five percent are women. The most subtle forms of pressure can be applied to patients who incur the displeasure of any nursing home personnel, from administrator to orderly. A patient requiring feeding can be fed just a little too quickly, turning mealtimes into a horror. A patient needing assistance in reaching the bathroom or turning in bed can be ignored. And, of course, there exists the more direct physical abuse found by the Senate Committee on Aging.

The vulnerability of patients also requires outside assistance for their protection. Almost no patients have financial resources to hire lawyers. A recent survey showed that half the patients had no regular contact with families or friends. When family members complain, they are often told to remove the aged relative, although there may be no other available means of care. Most families do not complain; more likely they pay small bribes to aides and orderlies in the hope they will not mistreat

their relatives.

We support legislation and administrative action to provide ombudsman protection to nursing home patients. The ombudsman should have the full range of powers to enforce the laws, regulations and rights of patients through negotiation, administrative action and lawsuits, if necessary. The ombudsman must have free access to homes and to patients in confidential settings, protected by law from disclosing the identity of complainants. This office, to serve patients in more than 200 homes throughout the state, must be adequately staffed. Otherwise it becomes a form of tokenism which accomplishes little but gives the public the false impression that patients are receiving needed assistance.

Public Disclosure

Issues relating to public access to information concerning nursing homes would seem to require little comment. The Social Security Act requires that the annual inspection reports be available to the public, but they are buried in local Social Security offices. Only a miniscule number of people know of the availability of inspection reports to the public. Our information and experience is that only the most persistent inquirer actually gets to see the reports. It is hard to imagine a sick, elderly person about to enter a nursing home being able to go to a Social Security office to examine

inspection reports, nor are their relatives or friends likely to do so. And certainly doctors who refer patients to homes are not going to spend their highly compensated time chasing inspection reports. The result is that typical lip service is given to the legal requirement, but in practice no meaningful attempt has been made to get information about nursing home conditions into the hands of those who make the decision about placements.

State regulations should immediately be amended to require each nursing home to provide copies of the most recent annual inspection reports (and all subsequent reports when additional inspections are conducted) to all patients and to post the report in a prominent place in the nursing home where it can be seen by visitors and potential patients. In addition, there should be a requirement that the nursing home deliver a copy of the inspection report to every potential patient or any other person to whom promotional literature is provided by the nursing home.

Of particular importance is getting the information to doctors who are responsible for a major portion of nursing home placements. The Senate Committee on Aging declared in March, 1975 that "physicians have shunned their responsibility for nursing home patients. With the exception of a small minority, doctors are infrequent visitors to nursing homes." One method of increasing the responsibility of physicians is to place the information before them so

they cannot close their eyes to conditions in nursing homes to which they assign their patients. The nursing home should be required to send a copy to each doctor who refers a patient to the home and to the current attending physician of each patient. In addition, the State Department of Health should send reports directly to physicians on request, and publicize this service through the medical societies and other available media.

In addition to inspection reports, there is another area of information which should be publicly available--information relating to the amount of personalized health-related services each patient in the home receives. Such information includes medical examination, dentist visits, eye examinations, various forms of therapy. Information as to the number of patients receiving each such service and the frequency thereof should be available to prospective patients.

Personnel Training

There is an urgent need for adequate training for the non-professional staffs, the people who in the real world of the nursing home are responsible for almost all direct patient contact. The Senate Committee on Aging, in a report just issued in April, 1975 found that aides and orderlies provide 80 to 90 percent of the care in nursing homes. The report continues:

"Only one-half of the 280,000 aides and orderlies are high school graduates. Most have no training. Most have no previous experience. They are grossly overworked and paid the minimum wage. It is little wonder that they show a turnover rate of 75 percent a year. Put simply, the absence of RN's and the reliance on untrained aides and orderlies result in poor care. Poor care runs the gamut from essential tests not being performed to negligence leading to death and injury."

I do not have much confidence in most training programs conducted by or under the direction of administrators of nursing homes. There programs will reflect the attitudes of the administrator. Those seeking to minimize labor costs are unlikely to explain to their employees the nature and scope of responsibilities towards patients that the employees should rightly understand. Furthermore, few administrators have actual training in problems of the aged. We propose a program of mandatory training for all employees having regular patient contact. These training programs should be either directly state operated or state supported through universities, community colleges and other educational institutions. Employees must be paid for time spent in training programs, otherwise they will not attend or will resent the requirement. An initial course should be mandatory, to begin within one month of employment, with annual follow-ups also required.

Home Health Care

Many residences of nursing homes are there only because there is no other way currently available to finance their personal care needs outside these institutions. Even in the best of conditions in a nursing home, many patients would live a more normal, satisfying life in a private residence with family or friends. The National Council of Senior Citizens believes this can be accomplished, and a savings of public funds achieved at the same time, by direct payments to persons eligible for Medicaid benefits in a nursing home of an amount equal to three-quarters of the average amount that would be paid to an institution. The patient receiving the payment and his or her relatives and friends would then assume responsibility for obtaining personal and health care.

Under the Social Security Act, the state must include home health services in its Medicaid program, but only for patients eligible for skilled nursing services. New Jersey presently provides home health services only to this limited required group. According to the Department of Institutions and Agencies, about 2,300 persons received home health services in fiscal 1976, compared with 17,000 nursing home patients. The total budgeted costs for home health services is only $666,000 in fiscal 1976. The Social Security Act permits federal reimbursement to states for a broad range of home health services, beyond that minimally required for skilled nursing patients. The New

Jersey Medical Assistance and Health Services Act permits the state to take advantage of federal reimbursement for health home services for a broad range of Medicaid patients. All that is required to start the process is a change in administrative regulations.

However, federal reimbursement is tied to establishment of home health service agencies and services which are not readily available in many areas of the state. As a result, implementation of even a broadened program of home health service under the federal program will be slow.

We urge the state of New Jersey to proceed with its own program without waiting for the complex requirements for Medicaid participation to be satisfied. A pilot program should be introduced to allow Medicaid patients eligible for nursing home care to volutnarily choose to live in a private residence and to receive necessary care through a combination of home health services and voluntary care by relatives and friends. A flat payment to the Medicaid patient should be made to cover all services rendered by a nursing home. The patient, his or her family and friends and the attending physician will then have the primary responsibility for arranging the services, with supportive counseling services provided by the state. As noted, we believe the level of payment should be seventy-five percent of average cost of institutionalization. However, pending development of a federally approved program subject to federal cost sharing, the program could be instituted by the state alone at no additional cost by a payment rate

of fifty percent, the state's share of the Medicaid payment. Such a pilot program could be speedily implemented, applicable to both skilled and intermediate care Medicaid patients. It would provide valuable information on the potential and problems of a broad home health care program. To protect and assist the patients in such a program, the state should arrange periodic home visits by a visiting nurse and the same periodic medical examinations presently required for nursing home patients.

Legislation to clarify authority for such a program under the New Jersey Medical Assistance and Health Services Act and to coordinate with other income maintenance programs would be desirable.

STATEMENT OF OSA JACKSON BEFORE THE
NEW JERSEY NURSING HOME INVESTIGATION COMMITTEE
MAY 2, 1975

My name is Osa Jackson. I have worked as a physical therapist in nursing homes over the past three years. I am presently a doctoral candidate at the University of Michigan in the area of educational gerontology. My dissertation will focus on the delivery of physical therapy in nursing homes today. I have also worked as a physical therapy consultant to the Michigan Department of Public Health. As a professional working in the nursing home setting, I have seen several sides of the nursing home issue: the patients', the staffs', the administrators' and the health officials'.

I would like to discuss several issues which I feel are vital in our attempts to improve the life of the nursing home patient.

1. Increasing the efficiency and the effectiveness of the regulatory structure as a whole.

   a. The need for a policy of unannounced inspections.

   b. Thorough inspector training.

2. Thorough nurses aide and orderly training.

3. A therapeutic nursing home environment which is emotionally supportive and mentally stimulating.

Today there are approximately 16,000 nursing homes across the United States. Nursing home residents are people, human beings, and they are entitled to the same quality of care that is delivered to patients in short-term health care facilities. Good nursing home care is possible but state and federal policies and guidelines must reflect

the interest of the patients as well as the nursing home operators. There are many residents in nursing homes who could function effectively in the community if an effective program of home supportive services were available.

Home supportive services at this time are generally less expensive than nursing home care. (See Introductory Report, 1974 Senate Special Committee on Aging, Appendix 5.) Home supportive services are not available in many areas of the type and quantity needed. This is perhaps one reason why there are so many nursing home patients who appear to be inappropriately placed. Until more and better home supportive services are available, there is a great need to attempt to improve the life of the nursing home patients.

At the same time, governmental effort is needed to plan for and create those sorely needed home health care services. Institutionalization is traumatic and should always be used as a last resort--unfortunately, today there is no other alternative for the majority of America's elderly.

Thousands of Americans are presently residing in nursing homes and they are the victims of our problem-ridden long-term care delivery system. There are laws and regulations, however, on the books, which, if they were stringently enforced, could drastically improve the life of nursing home residents. At the present time, the reimbursement formula provides little or no incentive for the nursing homes to comply with the rules and regulations. Federal

payments are made to nursing homes whether or not they have major violations. Also, under the present reimbursement structure, the nursing home gets a higher per diem rate for the critically ill patient, so there is very little incentive to rehabilitate the patient within a reasonable period of time.

There is a grave need for a good, complete inspection system. Quality of care is the issue that needs to be talked about. The quality of care delivered in a nursing home cannot humanly be measured by examining only the written policy statements that the facility is required by law to have. The quality of care is not measured by examining how many pieces of equipment the facility has, although that is a good indicator. Both of these variables are examples of measuring a potential for the delivery of nursing home care, but not a measurement of actual care. The previously mentioned measures are necessary, but to establish what the quality of care is, it is necessary for an inspector to examine patients. A patient who is receiving good personal care should look essentially like any person in this room--clean. That should be easy to define: finger and toe nails well groomed, hair clean and combed, clothes clean, teeth fitted and clean and, if ambulatory, wearing shoes and socks. This, of course, is an overall appearance criterion and must be used to supplement an examination of nursing and medical practices. Talking with patients can also provide a good picture of their emotional status and the atmosphere of the facility.

This, of course, should be done on a confidential one-to-one basis, so that the patient can feel free to express himself. I have too often seen an inspector with the head nurse at her side try to interview a patient. In that situation, even the alert and generally vocal patient will fake senility. To speak honestly and frankly in such a situation would leave the patient open to recrimination and retaliation.

There is a vital need for states to adopt unannounced inspections as part of their inspection procedure. In the methodological description of a recent HEW survey, the visits to the nursing home "were unannounced so that an accurate profile of the normal operations could be obtained." (Long-Term Care Facility Survey, Interim Report, U.S. Department of Health, Education and Welfare, Public Health Service, Office of Nursing Home Affairs, March 1975, p. 3.) This survey was carried out in order to obtain baseline data on the quality of skilled nursing home care. HEW felt the need to use unannounced inspections to get a clear, valid picture of day-to-day operations in a nursing home. This should function as an example to state inspection agencies. Unannounced inspections are vitally needed. In many states, unannounced inspections are carried out routinely to insure the quality of care of animals in pet shops (e.g., Michigan). I strongly feel that the elderly patients

deserve the same vigilance and concern for their welfare. Unannounced inspections are especially needed at night, when staffing problems are most common. A shortage of staff is known to result in increased patient abuse, use of restraints and overmedication. A shortage of staff is also unfair to the aide, since one human being can only enjoy doing his job if he is doing a reasonable amount of work. The patient is the innocent victim of the crime of understaffing.

The unannounced inspections should focus on the quality of care that is being delivered. The point is, if the government is spending money on a regulatory structure, it would seem logical that they should strive to see the complete picture of what is going on. The nursing home patients have been or are taxpayers; they deserve to get their money's worth. With announced inspections the regulatory function of the health officials becomes muted since new linens, blankets, patient gowns, etc. are brought out of storage for that occasion and a good, thorough housecleaning is done. I have observed this happen time and again. Above all, a nursing home should be required to post all their inspection results so that the consumer can have a true picture of the kind of service that the facility delivers. A monthly or bi-monthly rating based on inspection results should also be available to consumers so that they can make intelligent decisions about where to buy the best nursing home care.

The next issue of concern is the training of nursing

home inspectors or surveyors. The federal government last August enacted legislation (P.L. 92-603) which authorizes the HEW to fund 100% of the cost of training state inspectors. A two-week stay in a nursing home would be an ideal requirement for any new public health official, so that he could observe first-hand the system which he is trying to regulate. Nursing home inspectors are a vital link in the long-term health care delivery system. They need to have as much preparation as possible. The state of Connecticut has a good example of an adequate inspector training program.

There is a great need to coordinate and compile the information gathered by the inspection reports. There is no complete file on a nursing home which is easily retrievable for the inspector. If this was the case, follow-up visits would make a lot more sense, since the inspector would know what to look for. At the same time there is a need for procedural precautions to avoid conflict of interest situations. It is not uncommon that if a nursing home inspector is responsible for the same facility year after year, he will develop an ongoing friendship with the administrator. In that case, he may not be able to evaluate the facility as critically as his job calls for.

There is a strong need for some mechanism for training nurses aides and orderlies. The Senate Special Committee on Aging on March 3, 1975 released Supporting Paper No. 3 in the series entitled Nursing Home Care in the U.S.: A Failure in Public Policy. One fact that was pointed out was that 80-90% of care in nursing facilities is given by

aides and orderlies (trained--how well?), paid the minimum wage and showing a turnover rate of 75% per year (p. 352). To provide a good, thorough and educationally stimulating training for nurse's aides (that means that the aides do not sleep through the session), it is necessary to have a good pool of resources to draw on. As an educator, I see the need for the state to play a vital role as a support mechanism to help the in-service training directors. First and foremost, it would seem desirable to establish a criterion for the kind of in-service training needed for aides and orderlies in the nursing homes. The state with the help of nursing schools and other educational institutions could then establish a resource pool of printed material, films and speakers. The other alternative is to use the community colleges to teach the basics of the nurse's aide training course. That could help the in-service director to fulfill the major functions of the position (on-the-job supervision, ongoing staff training, patient seminars, etc.). Such a centralization of nurse's aide training (even if it were just a basic 6-week course) could substantially improve the level of nursing home care. The nurse's aide would be better prepared to fulfill her role and personnel turnover would naturally decrease. It is also important to realize that at the present time, the kind of in-service training given by a facility is a direct reflection of the administrator's attitude toward his facility. In a good facility, the in-service training is

usually adequate but in a poorly administered facility, the in-service training can easily be a token effort. In many nursing homes where understaffing is a problem, the in-service director can easily end up being the floor nurse. In that situation, in-service training is only a paper entity. The result is that untrained persons are, in many cases, caring for critically ill patients who have special emotional and physical needs. A patient entering a nursing home deserves to have an aide who is prepared to work with him. Only in this way can a patient hope to reach his maximum level of physical functioning and emotional adjustment--which is the reason that he has entered the nursing home.

The last issue I will discuss concerns the resident or patient's mental and emotional sustinance. A nursing home cannot be like home. It can and should, however, be <u>funded</u> to provide daily activities, library service, etc. and monthly outings as tolerated by the residents. It is only natural that if a person is placed in a room with blank walls and only bingo games every two weeks, that he will withdraw and choose to die. Equally important is the need to provide an atmosphere of sanity and calm in a nursing home. There is also a great need to identify the senile, the emotionally disturbed and the patients with psychiatric problems. To use only medication to deal with these problems is not adequate. There is a need to develop therapeutic programs (milieu therapy, work therapy, reality orientation) to deal directly with the problems

and promote rehabilitation even if it is a slow, long-term process. This is one area in which in-service directors need to focus. At the present time senile and disturbed patients are either ignored("there is nothing we can do") or they are medicated so that they are invisible robots tied to their chairs. Medically, that is not defensible and something needs to be done so that the disturbed patient gets the psychiatric and emotional support he needs to deal with his condition as effectively as is possible. Without the proper care these patients greatly affect the lives of other patients in a very negative way.

Health professionals (occupational therapists, physical therapists, music therapists, speech therapists and social workers) as well as families, friends, librarians, etc. need to become actively involved in nursing homes. You and I will one day need a nursing home--good care can be and is delivered in some nursing homes today. Let us work to make all nursing homes functional and therapeutic health care facilities. To do this, state action will be needed to fine a Patient's Bill of Rights (e.g., Minnesota), provide for the dissemination of information about new treatment techniques and to create a reimbursement structure which motivates nursing home operators to develop and maintain a high quality of patient care standards.