non-binding recommendations on proposed fines against homes. Although recommended penalties can be appealed by homes, they are generally upheld in the administrative process and ultimately paid, says Ken Hamilton, deputy chief of licensure for the Division of Facility Services.

The committee is required by statute to include representatives of the nursing and rest home industries, a public representative, a nurse, and a pharmacist.[5] It also includes officials from the divisions of Aging, Social Services, and Facility Services, and a representative of the Secretary's Office in the Department of Human Resources.

The types of problems inspectors cite at nursing homes vary from minor paperwork violations to serious cases of abuse and neglect. Often, homes are cited for poor record-keeping. For example, staff must make note each time they give medication to a resident. They also must record any change in a resident's condition, such as the appearance of a bedsore or a significant weight loss.

In other cases, homes are cited for poor housekeeping or for failing to have enough staff on duty. And since many residents are on special diets, food service is another commonly cited area.

The most serious violations involve the actual care and treatment of patients. Homes have been fined for failing to reposition residents to prevent bedsores or for improperly restraining difficult patients. Or, they are cited for allowing confused residents to wander from the home. In several cases, the state has fined homes for failing to call a doctor to examine ill patients, some of whom later died.

The Penalty Review Committee is the target of many of the reformers' complaints. While nursing homes can appeal an unfavorable PRC decision, there is no such avenue for patients, family members, or advocates. But former committee member Robert Byrd, the administrator of the nursing home at Alamance Memorial Hospital in Burlington, says most people don't understand that many of the cases that come before the committee are "not clear-cut" and require a judgment call.

In some instances, resident rights groups want

—continued on page 28

A Road Map to North Carolina Nursing Home Regulation

As Americans live longer than ever before, more and more people can expect to spend time in a long-term health care facility. Some will enter rest homes that offer only residential and personal care, but many will enter nursing homes, which provide convalescent care and medical supervision.[1]

One study predicts that 43 percent of those people who turned 65 in 1990 will enter a nursing home before they die.[2] The authors conclude that health care resources will have to shift more toward nursing homes in the future as more and more people wind up in long-term care. Other research has focused more on quality of care. A study published in the Feb. 27, 1991, edition of the *Journal of the American Medical Association* found failure to adequately diagnose and treat depression increases by 59 percent the likelihood that a patient will die within the first year of admission to a nursing home.[3]

And a massive study by the federal government showed nursing homes in North Carolina to be below the national average on six of 32 performance indicators applied to 15,000 nursing homes nationwide.[4] In introducing the report, Gail Wilensky, administrator of the Health Care Financing Administration, wrote that it represented "neither the final, definitive word on nursing home performance nor a comprehensive guide to the selection of a nursing home." Still, the study suggests the need to pay careful attention to the quality of care provided in North Carolina's long-term care facilities.[5]

The state is likely to have an especially large number of aged patients in such facilities, as its elderly population is growing at a rate

—continued

nearly twice the national average.[6] In 1990, 12.13 percent of the state's population was over 65 years old compared to 12.7 percent of the population for the nation as a whole, says Bill Lamb, a planner in the Division of Aging. By 2000, the state's population over 65 is projected to have nearly caught up with that of the nation as a whole, reaching 12.93 percent compared to 13 percent nationally. And the state's 65-and-over segment is projected to surpass the national average soon thereafter.

But Lamb says growth in the North Carolina population over 85 is projected to take place at a much faster pace, from 1.06 percent of the state total in 1990 to 1.57 percent in 2000—a growth rate of 65.53 percent. "The fastest growing segment of folks is those over 85, and those are the people at most risk of nursing home care," says Lamb.

As of Jan. 1, 1992, there were more than 300 nursing homes operating in North Carolina, with a total bed count in excess of 30,000, according to the Licensure Section in the Division of Facility Services. The occupancy rate in these homes is high—over 91 percent in 1990.[7]

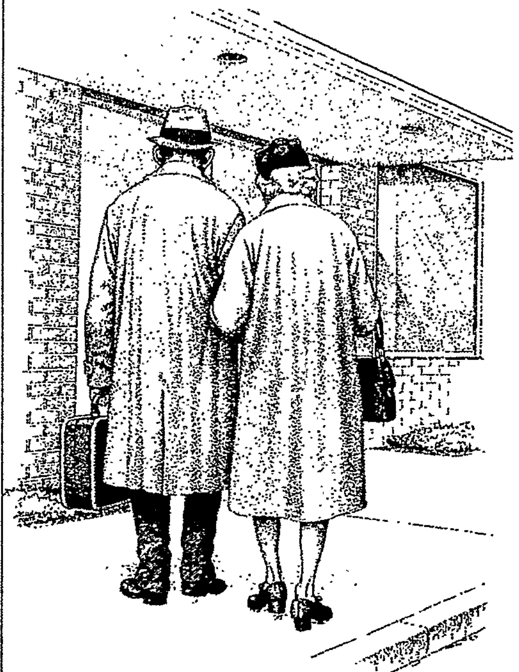
While more than 98 percent of North Carolina nursing homes are privately owned and managed, government at both the state and federal levels plays a major role in determining how nursing homes operate. First, the federal government requires that all facilities technically classified as nursing facilities provide a certain level of care. Since the Oct. 1, 1990, implementation of the Omnibus Budget Reconciliation Act, commonly known either as OBRA or the Nursing Home Reform Act, all nursing homes have been required by law to have a registered nurse on staff, and a licensed practical nurse on duty all the time.[8]

Second, the federal government's Medicaid program plays a major role in setting standards for nursing home operation. Medicaid pays the bills for about three-quarters of the state's nursing home patients. In order to receive these funds, all homes with Medicaid patients must conform to federally mandated requirements. Because such a high percentage of long-term care patients depend on Medicaid to pay for their care, these federal standards significantly affect the way facilities operate.

Like all other states, North Carolina has a great deal of regulatory responsibility within this federal framework. The state's regulatory vehicle is the Division of Facility Services in the Department of Human Resources. From its main office in Raleigh and branch offices in Black Mountain and Greenville, the Division of Facility Services regulates nursing homes across the state. Three sections within the Division of Facility Services—Certification, Licensure, and Construction—carry out inspections of nursing homes to ensure that regulations are being followed.

Construction Section officials perform a wide range of duties, including: checking building systems such as heat and emergency generators to make sure they are operating properly; conducting fire safety inspections; and reviewing plans for new facilities. *Certification* inspectors determine whether a given home may receive federal funds for Medicare and Medicaid patients. After passing the initial inspection, homes are subjected to annual certification inspections.

Licensure Section officials, among other duties, administer the most controversial component of nursing home regulation—the state's penalty process. Every nursing home must



have a state license issued by Facility Services before it can accept patients. To obtain a license, each home must pass an inspection by licensure inspectors, who decide whether the facility has the capability to provide services.

If an initial inspection reveals no problems, inspectors issue the home a full license. Thereafter, licensure inspectors visit facilities to respond to complaints about potential violations of state or federal law and to assess the quality of care provided. One group of 18 investigators works to investigate complaints, and another group of eight inspectors surveys the homes on a routine basis. These survey inspectors work in teams which always contain a nurse, and, frequently, a pharmacist or a dietician.

A nursing home that has violated North Carolina laws may be subject to administrative censure from Facility Services. When inspectors discover problems in a facility, the home has 10 days to correct the problem or to submit a plan for correcting it to Facility Services. If inspectors later find that the home hasn't corrected the problem, Facility Services may give the home a provisional license and suspend its right to accept new patients.

Facility Services may also assess financial penalties. Until October 1, 1987, all nursing home penalties were assessed at $10 per day per patient, regardless of the nature of the violation. Serious violations by a few homes, however, gave rise to the current system, which includes two broad tiers of penalties, Type A and Type B, and a wide range of potential fines.

A Type A violation is assessed for a situation that "creates a substantial risk that death or serious physical harm will occur or where such harm has occurred." The state assesses a penalty between $250 and $5,000 for each Type A violation.[9] Type A violations during the past few years have been assessed for a failure to notify a physician of a patient's rapidly deteriorating condition, failure to identify and treat bedsores, and inflicting physical and mental abuse on a patient.

Type B violations, on the other hand, are assessed for infractions that threaten the "health, safety and welfare of a resident" but do not "create substantial risk that death or serious physical harm will occur." Facility Services can impose a fine up to $500 for each Type B violation.[10] Type B penalties are administered for offenses ranging from not bathing a patient often enough, to storing medicines improperly, to failing to give a patient a prescribed diet. Both Type A and Type B penalties must be tripled for repeat violations of the same law or rule.

After inspectors cite a nursing home with a violation, they send a written report to the Licensure Section office in Raleigh. These inspectors do not recommend a penalty, but only give a description of the infraction which has occurred. At the central office in Raleigh, this report is examined by an internal review committee, composed of the assistant chief of licensure, one Division of Facility Services branch office head, and the section planner. This committee generally determines the type and amount of penalties after an informal hearing with the home operator and inspectors. It may also decide not to impose a penalty.

When it decides a penalty is warranted, however, the internal review committee makes a recommendation for the type and amount of penalty to the Division of Facility Services' Penalty Review Committee. This committee then reviews reports of the infraction and examines the recommendations of the internal group.

If a home that has not received any penalties for the previous twelve months is assessed a Type B violation, the sanctioned home may pay its penalty without having to go before the Penalty Review Committee. Few homes choose to do this, however, because it could be construed as an admission of guilt, and could be used as evidence in lawsuits brought against them.

State law mandates that the nine-member Penalty Review Committee include representatives from both the domiciliary home and the nursing home industries, a member of the general public, a registered nurse, and a licensed pharmacist.[11] Currently, though this is not mandated by statute, representatives from the Department of Social Services and the Division of Aging, a nursing home administrator, and a Facility Services official also serve on the committee.

—continued on next page

At a meeting open to the public, the Penalty Review Committee reviews the recommendation of the internal review committee, and then decides whether to approve the penalty recommended. While the Licensure Section chief has the authority to overrule the Penalty Review Committee, current policy is to avoid such unilateral decision making.

If a fine is levied by the Division of Facility Services, the home has 30 days to appeal the penalty. In the event that a home decides to appeal a Penalty Review Committee judgment, it argues its case before an administrative law judge. This judge makes a verdict and sends it to the head of the Division of Facility Services, who has final agency approval. If the home still isn't satisfied with the judgment, it can initiate formal court proceedings by appealing to Superior Court. — *Paul Barringer*

FOOTNOTES

[1] There are three types of rest homes, or domiciliary homes. They are homes for the aged and disabled, family care homes, and group homes for developmentally disabled adults. Medical care at these homes is occasional or incidental (G.S. 131D-20(2)). Nursing homes, on the other hand, are for people who need regular medical attention but are not sick enough to require hospitalization (G.S. 131E-101(6)).

[2] Peter Kemper and Christopher Murtaugh, "Lifetime Use of Nursing Home Care," *New England Journal of Medicine,* Vol. XX, No. 1911, p. 595.

[3] "Long-Term Care: Two Studies Gloomy about Nursing Home Care," *Modern Healthcare,* March 4, 1991, p. 22.

[4] Tinker Ready, "Nursing Homes Survey," *The News and Observer* of Raleigh, May 24, 1990, p. 4B.

[5] The introduction also included a section on uses and limitations of the data which noted: information contained in the report comprises the individual judgments of more than 3,000 surveyors in 53 state survey agencies; deficiency findings are not a complete picture of the quality of care rendered by a nursing home; and findings are a snapshot of conditions found in a home at the time of the survey. For more, see "Medicare/Medicaid Nursing Home Information, 1988-1989, North Carolina," U.S. Department of Health and Human Services, Health Care Financing Administration, 1990, pp. I-III. Copies of the study are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

[6] *North Carolina Aging Services Plan,* Department of Human Resources, Division of Aging, 1991, p. 11.

[7] "Health Facilities Data Book, Nursing Home Summary Report—1990 Data, State Center for Health and Environmental Statistics, October 1991, p. 279.

[8] Rules for the Licensing of Nursing Homes, 10 N.C. Administrative Code 3H .0507(d).

[9] G.S. 131E-129(a)(1).

[10] G.S. 131E-129(a)(2).

[11] G.S. 131D-34(h).

to blame the homes for injuries or deaths that are not the homes' fault, Byrd says. "Sometimes, I think certain people are on a witch hunt," he says. "[They think] if there is a bad outcome, a violation must have occurred, but that's not always the case. Outcomes are a factor of many variables, and one of those variables is what the home did or didn't do."

Christine Heinberg, a lawyer with North Carolina Legal Assistance—A Mental Disability Law Project, agrees that some cases require a judgment call. But she also agrees with other residents' advocates who say the committee members tend to make the calls in favor of the home operators. "The people who watch [the committee] think they are more concerned with protecting the rights of the facilities than they are with protecting individual patients," she says.

Souza, however, takes the opposite view. "I absolutely disagree with that," he says. "The Penalty Review Committee almost all the time will take the recommended fine."

Lower Fines, But More of Them

Since 1988, the state has prepared annual reports based on the minutes of the Penalty Review Committee. The Center's examination of the reports and minutes of Penalty Review Committee meetings through July 1991 shows that 149 of the state's 290 homes have been fined since 1988 (See Table 2, p. 30 for more). The remaining 141 homes operated the entire three-and-a-half year period without a single penalty.

The records examined by the Center indicate which homes were fined and by how much. They do not indicate the outcome of any appeal, nor do they reflect informal agreements by homes to pay B-level fines without subjecting themselves to the penalty review process. Still, the number and amount of fines provides a solid indicator of where licensure officials thought there was enough of a problem with a nursing home's operations to institute an administrative penalty.