AN APPRAISAL OF THE NURSING HOME ENFORCEMENT PROCESS

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Increased life spans and recent developments in social welfare policy have produced a proliferation of the health care facility known as the nursing home. Tracing its origins to the "indoor relief" provisions of medieval poor laws which decreed that paupers must reside in institutions to be eligible for public support,[1] the nursing home has experienced dramatic growth since the enactment of Medicare and Medicaid in 1965.[2] There are now more than 20,000 nursing homes in America[3] and nursing home revenues exceed $7 billion, of which more than one-half is public funds.[4]

More than a million persons live in nursing homes.[5] The average

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1. *See generally* W. THOMAS, NURSING HOMES AND PUBLIC POLICY: DRIFT AND DECISION IN NEW YORK STATE 15-49 (1969).

2. In the 10-year period from 1960 to 1970, the number of nursing home facilities increased by 140 percent, beds by 232 percent, patients by 210 percent, employees by 405 percent, and expenditures for care by 465 percent. From 1960 to 1973, total expenditures increased by almost 1,400 percent. SUBCOMMITTEE ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, 93D CONG., 2D SESS., NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, SUPPORTING PAPER NO. 2, DRUGS IN NURSING HOMES: MISUSE, HIGH COSTS, AND KICKBACKS xii (Comm. Print 1975) [hereinafter cited as SUPPORTING PAPER NO. 2]. Public expenditures in the nursing home industry have increased from $907 million in 1967 to nearly $4 billion by 1974. Worthington, *National Health Expenditures, 1929-74*, SOC. SEC. BULL. 4, 5 (1975).

3. SUBCOMMITTEE ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, S. REP. NO. 93-1420, 93d Cong., 2d Sess. (1974) [hereinafter cited as INTRODUCTORY REP.].

4. Based on estimates provided by the Social Security Administration [SSA] for 1974, Medicaid will pay for about 50 percent of the national nursing home bill of more than $7.5 billion. The Medicare program will pay for about 3 percent. SUPPORTING PAPER NO. 2, *supra* note 2, at xii.

5. INTRODUCTORY REP., *supra* note 3, at 15. This was the figure at the end of 1971. Because of patient turnover, it has been estimated that one elderly person in five

age of nursing home residents is 82 and most suffer from several chronic diseases.[6] Many must depend on others for help in daily activities—fewer than half can walk or bathe themselves unassisted, nearly one-half require assistance in dressing, and about one in 10 needs assistance eating.[7] Many nursing home residents are also socially isolated; more than half are widowed; and nearly half have no viable relationship with close relatives.[8]

We entrust nursing homes with the care of this very special group of Americans and spend vast sums to pay for their care. More than 75 percent of the nursing homes in the United States, supplying two-thirds of the available nursing beds, are operated for profit.[9] In some homes, the care we desire is provided compassionately and competently. In others, it is not. Indeed, evidence is mounting that more than half the nursing homes in this nation are abusing the public trust;[10] patients frequently are neglected or physically abused, their money and property is stolen, their very lives are endangered, and massive misuse of public funds is commonplace in the industry. Further, despite the nation's enormous moral and monetary investment in the nursing home industry, public agencies entrusted with the regulation of nursing homes have been ineffectual in preventing these abuses.

The purpose of this Article is to describe existing nursing home conditions and to offer suggestions to improve public enforcement strategies as well as alternatives to public enforcement. The Article is divided into three parts. The first describes the industry and considers the role of federal and state governments in establishing stand-

will spend some time in a nursing home during his life. On any given day, roughly 5 percent of the nation's elderly are in institutions. *Id., citing* Kastenbaum, *The Four Percent Fallacy*, 4 AGING AND HUMAN DEVELOPMENT No. 1 (1973).

6. INTRODUCTORY REP., *supra* note 3, at 16-17. Studies reveal that the average nursing home patient has several disabilities, frequently including cardiovascular disease, fractures, arthritis, and cerebral arteriosclerosis. Cerebral arteriosclerosis, a hardening of the arteries that restricts the flow of blood to the brain, may induce a mental state of confusion or a return to childhood memories. Nursing home staffs often label such a patient as senile to justify their treating the patient as one would a child. C. TOWNSEND, OLD AGE: THE LAST SEGREGATION, THE NADER REPORT 125-26 (1971).

7. INTRODUCTORY REP., *supra* note 3, at 17. In an institution, many of the tasks which one ordinarily performs for himself, such as preparing and serving food, washing and drying laundry, and administering medication, are performed by others. Thus, in numerous ways an individual is directly dependent upon others for the quality of his environment.

8. *Id.* at 16.

9. Fifteen percent of the nursing homes, accounting for 25 percent of all beds are nonprofit facilities. Eight percent of the homes and beds are operated by governmental entities, such as counties. INTRODUCTORY REP., *supra* note 3, at 22.

10. For example, a May 1971 General Accounting Office report on the enforcement of Medicaid and Medicare standards in 90 nursing homes in Oklahoma, New York, and Michigan revealed that at least 50 percent had serious deficiencies. GAO, PROBLEMS IN PROVIDING PROPER CARE TO MEDICAID AND MEDICARE PATIENTS IN SKILLED NURSING HOMES (1971). Indicative of the serious deficiencies that were found, 48 of the 90 homes lacked adequate nursing staff, 47 lacked adequate physician attendance, and 44 did not meet fire safety standards.

ards of quality. The second examines existing enforcement devices utilized to induce compliance with these standards and suggests how enforcement might be made more effective. Finally, attention is focused on how patients and patients' advocates can use private sanctions to protect patient rights and improve the quality of care provided in nursing homes.

I. THE INDUSTRY AND THE GOVERNMENT ESTABLISHING STANDARDS OF QUALITY

A. *Public Funding of Nursing Homes*

1. *Definitions.* In general, nursing homes are facilities which provide medical services to individuals not needing the extensive medical care available in general hospitals. The term encompasses two principal types of facilities that are classified according to the nature of the care they provide.

The most intensive care is provided by skilled nursing facilities [SNF], which offer 24-hour nursing care under the supervision of a registered nurse.[11] Presently, there are over 9,000 SNF's with nearly 650,000 beds.[12] SNF facilities, which are very expensive, often exceeding $1,000 per month, are regulated by the United States Department of Health, Education, and Welfare [HEW] and by the states.

The next level of nursing home care[13] is provided by intermediate care facilities [ICF]. An ICF provides health-related care and services to individuals who do not require the degree of care which an SNF is designed to provide, but who because of their mental or physical condition require some care[14] above the level of room and board. There are about 4,500 ICF's in the United States, with about 220,000

11. Basically, a skilled nursing facility [SNF] is an institution primarily engaged in providing to patients skilled nursing care and related services or rehabilitation services. The elements which an institution must satisfy in order to be deemed an SNF are set forth at 42 U.S.C. § 1395x(j) (Supp. II, 1972). The regulations of the Secretary expand the statutory definition by describing skilled nursing services. *See* 20 C.F.R. §§ 405.1101-.1137 (1974).

12. INTRODUCTORY REP., *supra* note 3, at 20.

13. A third type of nursing home is the custodial care facility, sometimes called board and care homes, personal care homes, or domiciliary homes. These facilities are not truly nursing homes for they provide no nursing services; only custodial services, such as assistance in bathing, dressing, and eating are supplied. These facilities are regulated only by the states, and the care they provide is not eligible for reimbursement under either Medicare or Medicaid. There are about 9,000 of these facilities in the United States, with approximately 250,000 beds. Residents of such facilities often suffer from the same problems as residents of ICF and SNF facilities. However, because board and care homes are not eligible for Medicare and Medicaid reimbursement and because they are governed by regulatory agencies that are different from those responsible for SNF's or ICF's, this Article will not focus upon them.

14. *See* 42 U.S.C. § 1396d(c) (1970), *as amended*, (Supp. III, 1973). *See also* 39 FED. REG. 2223-26 (1974). For a discussion of the regulations, see text & notes 90-104 *infra*.

beds.[15] ICF care is less expensive than care in SNF's[16] and, while ICF's can be reimbursed by Medicaid, they are not eligible for Medicare funding. ICF's also are subject to both state and HEW regulation.[17]

2. *Medicaid.* The role of the public purse in the nursing home industry is substantial, and the greatest share of this expense results from the Medicaid program, which pays for over one-half of the nation's nursing home bills.[18] Medicaid[19] is designed to provide adequate medical care to indigent persons, some of whom are elderly.[20] The program provides funds to each participating state to assist it in furnishing medical, rehabilitative, and other services to those who otherwise could not afford them. Coverage for numerous nursing home services,[21] including care provided by SNF's and ICF's, without limitation as to length of stay, is provided. The proportion of the cost which the federal government provides to each state depends on the per capita income of that state and ranges from 50 to 83 percent.[22] The balance of Medicaid expenditures is borne by state and local governments.

Nursing homes are reimbursed by the states for care provided to persons eligible for Medicaid. The reimbursement system, established by each state and approved by HEW, must provide that payment not be "in excess of reasonable charges consistent with efficiency, economy, and quality of care."[23] According to a 1970 study, patient reimbursement rates varied from $4.53 to $68.17 per day.[24] Accept-

15. INTRODUCTORY REP., *supra* note 3, at 20.

16. ICF's were developed as a solution to the practice of housing poor persons not needing skilled nursing care in SNF's because SNF care would be paid by Medicaid rather than by the states. *See generally* INTRODUCTORY REP., *supra* note 3, at 39-40; Note, *Governmental Regulation of Nursing Homes—An Inquiry,* 1973 UTAH L. REV. 270, 277. In an effort to reduce the cost of caring for this population, Congress directed that ICF care be eligible for reimbursement.

A reasonable cost differential between SNF and ICF care is required by 42 U.S.C. § 1396b(h) (Supp. II, 1972). If such differential does not exist, the Secretary is authorized to reduce payments to the state in an amount which is the reasonable equivalent of the difference between what the state spent for ICF services and what it would have spent had a reasonable cost differential existed. *Id.*

17. The definition of an ICF indicates that whatever state requirements are preconditions to obtaining a license from the state must be met and that state safety and sanitation requirements must be met as well. *See* text & note 14 *supra.*

18. SUPPORTING PAPER No. 2, *supra* note 2, at xii.

19. Title XIX of the Social Security Act of 1935, 42 U.S.C. §§ 1396-1396i (1970), *as amended,* (Supp. III, 1973).

20. For a brief discussion of the Medicaid program, see Note, *Medicare and Medicaid: The Failure of the Present Health Care System for the Elderly,* 17 ARIZ. L. REV. 522 (1975).

21. *See* 42 U.S.C. §§ 1396d(a)(1)-(17) (1970), *as amended,* (Supp. III, 1972). *See generally* Note, *supra* note 20.

22. 42 U.S.C. § 1396d(b) (1970), *as amended,* (Supp. III, 1972).

23. 42 U.S.C. § 1396a(a)(30) (1970). A supplemental regulation, 45 C.F.R. § 250.30(b) (1974), provides guidance for determining the acceptable upper limit for Medicaid payments.

24. COMPTROLLER GENERAL OF THE U.S., REPORT TO THE CONG., PROBLEMS IN PROVIDING GUIDANCE TO STATES IN ESTABLISHING RATES OF PAYMENT FOR NURSING HOME CARE UNDER THE MEDICAID PROGRAM 8-25 (1972).

ance of Medicaid reimbursement for care provided to a Medicaid recipient is payment-in-full for these services and a home cannot properly seek supplemental payment from a patient, his family, or friends.[25]

States have adopted two basic systems of reimbursement.[26] In some states, homes are paid a flat fee for each Medicaid patient. In others, homes are reimbursed for reasonable costs incurred in supplying services. Under a flat fee system, each facility receives the same amount per patient, irrespective of the services actually provided. Because the fee often is insufficient to cover the costs of providing adequate care, facilities refuse to accept Medicaid patients or reduce the quality of care to clearly inadequate levels.[27] The reasonable cost system of reimbursement seeks to rectify this deficiency by basing reimbursement on the actual cost of providing care. This system enables states to adjust payments to account for factors such as economy of scale differences; differences in the quality of environment, care, and services; and differences in the cost of operation between urban and rural areas.[28] By providing reasonable reimbursement rates,[29] this system may also induce the construction of new homes where there is an undersupply of homes.

Each state participating in Medicaid must agree to abide by federal law and regulations and must submit to HEW a plan describing how it will administer the program.[30] This plan must designate an agency

25. 45 C.F.R. § 250.30(a)(7) (1974). This regulation requires the phasing out of any existing programs of supplementation and limits participation to providers who accept the amounts provided by Medicaid as payment in full. This regulation was upheld in Johnson's Professional Nursing Home v. Weinberger, 490 F.2d 841 (5th Cir. 1974).

26. INTRODUCTORY REP., *supra* note 3, at 39.

27. Courts have upheld reimbursement rates which are less than the reasonable costs of the services provided, however. Idaho Corp. of Benedictine Sisters v. Marks, No. 1-72-169, [1974 Transfer Binder] CCH MEDICARE-MEDICAID GUIDE, ¶ 26,768 (D. Idaho 1973). The court upheld the state's maximum limit of $11.50 per day per patient for SNF care notwithstanding the fact that reasonable costs may exceed this amount in many cases. It was determined that such a limitation reflected legitimate public purposes and that it did not violate the constitutional guarantees of substantive due process or equal protection.

28. N.Y. PUB. HEALTH LAW § 2807(3) (McKinney Supp. 1974) sets forth requirements for payments for hospitals or health-related services. Prior to approval of rates, the commissioner of health must certify to the budget director that rate schedules are "reasonably related to the costs of efficient production of such service." In making his certification the commissioner is required to take into consideration the

> elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital or agency is located, the rate of increase or decrease of the economy in the area in which the hospital or agency is located, costs of hospitals or agencies of comparable size, and the need for incentives to improve services and institute economies.

Id.

29. The Social Security Amendments of 1972 require all states to reimburse for SNF and ICF services on a reasonable cost related basis by July 1, 1976. 42 U.S.C. § 1396a (a)(13)(E) (Supp. II, 1972). The reasonable cost related basis is to be determined in accordance with methods and standards developed by the state on the basis of cost finding methods approved and verified by the Secretary.

30. 42 U.S.C. § 1396a (1970), *as amended*, (Supp. III, 1973).

of the state to serve as the "single state agency" responsible for Medicaid administration. This agency, often the state welfare agency, may delegate certain responsibilities, such as inspection for compliance with health standards, to another agency, such as the state health department.[31]

There are two types of eligible individuals under Medicaid: those who are categorically needy and those who are medically needy. Persons receiving aid to families with dependent children [AFDC] or supplemental security income [SSI] fall within the first category.[32] Persons eligible under the medically needy classification are individuals whose assets and income exceed allowable limits for AFDC or SSI eligibility, but who lack sufficient income and resources to meet the costs of necessary medical care.[33] Some nursing home residents who are Medicaid recipients were in one of the two eligible classes when they entered the facility. Others entered the facility as "private pay patients" and became eligible for Medicaid only after their savings were depleted by the considerable cost of care.[34]

3. *Medicare.* Medicare[35] is divided into two parts: Hospital Insurance Benefits for the Aged and Disabled, part A,[36] and part B, Supplementary Medical Insurance Benefits for the Aged and Disabled.[37] To be eligible for Medicare an individual must either be at least 65 or disabled;[38] there is no requirement of financial need. An individual

31. *Id.* § 1396a(a)(33)(B) provides that the agency designated by the Secretary to perform inspections to determine a facility's compliance with conditions of participation for Medicare may be used by the single state agency to perform the same task for it. If this inspection agency is not the organization responsible for licensing health institutions, that organization is to perform the surveillance duties.

32. *Id.* § 1396a(a)(10) (1970), *as amended,* (Supp. III, 1973). These individuals are to receive at least the same level of assistance as is made available to individuals under any other state plan. *Id.* § 1396a(a)(10)(B)(i).

With respect to the categorically needy group, the states have some leeway in determining financial eligibility of supplemental security income [SSI] recipients. In the case of aged, blind, and disabled individuals, a state may:

(1) provide for categorically needy coverage only for persons receiving or eligible for SSI benefits. In such a case, the SSI eligibility conditions must be applied by the state;

(2) provide for categorically needy coverage for all persons receiving or eligible for SSI benefits, and persons receiving a state supplementary payment. In such a case, the SSI eligibility standards must be applied to those persons who are eligible for or receiving only SSI; the state's supplementary payment program's eligibility conditions must be applied to persons receiving state benefits.

45 C.F.R. § 248.3(1) (1974).

33. 42 U.S.C. § 1396a(a)(10)(C) (1970), *as amended,* (Supp. III, 1973).

34. For examples of the high cost of care, see N.Y. Times, Sept. 16, 1974, at 39, col. 1.

35. Title XVIII of the Social Security Act of 1935, 42 U.S.C. § 1395 (1970). For a brief discussion of the Medicare program, see Note, *supra* note 20; Note, *supra* note 16.

36. 42 U.S.C. §§ 1395c-1395i-2 (1970), *as amended,* (Supp. III, 1973).

37. *Id.* §§ 1395j-1395w.

38. *See id.* §§ 1395c, 1395j.

is entitled to have payments made on his behalf for up to 100 days, during any spell of illness[39] or post-hospital extended care services.[40] Under Medicare, SNF's are reimbursed for actual costs incurred in providing care to eligible individuals. Allowable costs are limited to those which are reasonable and which relate to patient care. In addition to the direct costs of care, other institutional costs, such as depreciation and interest, can be reimbursed under Medicare.[41] The responsibility of processing Medicare claims for reimbursement has been delegated to private insurance carriers, such as Blue Cross, which are called fiscal intermediaries.[42]

Medicare plays a much smaller role in nursing home funding than does Medicaid. While care provided by an SNF is covered by Medicare, ICF care is not. Totally, the program only pays about 3 percent of the cost of nursing home care.[43] This figure is so much lower than Medicaid's contribution because Medicare coverage is far more limited and because some homes participating in Medicaid have elected to forego any participation in Medicare.[44]

4. *Other Governmental Support.* Federal funds also are involved in the nursing home industry through several other programs. In all, the federal government aids nursing homes through more than 50 programs,[45] including the Hill-Burton Act,[46] and programs administered

39. "Spell of illness" is defined at 42 U.S.C. § 1395x(a) (1970), *as amended*, (Supp. II, 1972).

40. 42 U.S.C. § 1396d (1970), *as amended*, (Supp. III, 1973).

41. For a brief discussion of allowable costs under Medicare, see [1974 Transfer Binder] CCH MEDICARE-MEDICAID GUIDE 1619.

42. For a general discussion of the use of intermediaries in the Medicare system, see [1974 Transfer Binder] CCH MEDICARE-MEDICAID GUIDE ¶ 13,310. Although it is possible for an SNF to receive reimbursement directly from SSA for eligible services rendered, providers usually request reimbursement from fiscal intermediaries. An intermediary receives and reviews claims for reimbursement, determines what is payable and the reasonableness of costs, makes payments to providers for approved services at approved costs, audits records of providers, advises providers concerning government requirements for participation in Medicare, and seeks to assure compliance with governmental regulations. *See generally* NURSING HOME LAW MANUAL, *Financial Management* ¶¶ 2-5 (Aspen Systems Corp. publication 1974).

43. SUPPORTING PAPER NO. 2, *supra* note 2, at xii.

44. *See generally* INTRODUCTORY REP., *supra* note 3, at 32-35. Studies by the General Accounting Office reveal that many facilities that were participating in the Medicare program withdrew. A strong factor inducing such withdrawal is the fact that coverage for the services has sometimes been denied retroactively even after care had been provided. At that point the facility must turn directly to the former patient for reimbursement. Thus, retroactive denial may cause hardship to patients as well. The Social Security Amendments of 1972, 42 U.S.C. § 1395 (Supp. II, 1972), attempt to minimize this hardship. If neither the individual nor the provider knew or could reasonably have been expected to know that services were not covered, the Secretary will make payment. The Secretary also will act to protect the individual from liability where the provider should have known that the services would not be covered. For a discussion of this problem, see Axelrod, Butler & Wing, *Representation of Clients in Matters Relating to Hospital Bills*, 8 CLEARINGHOUSE REV. 541, 543-44 (1974); Health Law Project, U. Pa. Law School, *Medicare Level-of-Care Determinations*, 6 CLEARINGHOUSE REV. 234 (1972).

45. INTRODUCTORY REP. *supra* note 3, at 26.

46. 42 U.S.C. §§ 219 to 291*o*-1 (1970). The Hill-Burton Act, or Hospital Survey

by the Department of Housing and Urban Development,[47] the Small Business Administration,[48] and the Veterans Administration.[49] In addition, a number of states have programs which support the nursing home industry.[50]

B. *An Inventory of Problems Relating to Nursing Homes*

All nursing homes have problems. Even the best nursing homes are institutions whose residents are forced to adjust their lives to institutional routines, and many are far worse.[51] Over half do not meet basic fire safety standards,[52] and many are filthy, with rodent and roach infestation common. Nursing care is deficient; nurses' tasks often are performed by unskilled personnel because skilled personnel are not present.[53] Similarly, medical care often is inadequate, and medical

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and Construction Act of 1944, provides funds for hospital construction. Until the act was amended in 1954, only a minimal amount of funds was utilized for long term care institutions. As of 1970, the Hill-Burton program, which is administered by HEW, has provided $455 million for the construction of 1,598 nonprofit nursing homes. INTRODUCTORY REP., *supra* note 3, at 25.

47. The Department of Housing and Urban Development supports nursing homes by insuring loans for their construction under section 232 of the National Housing Act. 12 U.S.C. § 1715w (1970). By 1970, $573 million had been utilized in 759 projects. INTRODUCTORY REP., *supra* note 3, at 25. Section 232 is intended to assist in the provision of SNF's and ICF's.

48. Through 1971, the Small Business Administration extended 1,185 loans to propriety homes at a cost of $103.7 million. INTRODUCTORY REP., *supra* note 3, at 25; *see* 15 U.S.C. § 636 (1970).

49. The Veterans Administration provides about 19,300 skilled nursing beds to veterans in its own facilities at a cost of $121 million annually. It also contracts with private homes and states for such care, providing about 4,600 beds in community facilities at a yearly cost of $36.5 million. At a cost of $40.1 million annually, the Veterans Administration also provides 17,000 domiciliary beds, 11,130 of its own and about 6,000 under contract. INTRODUCTORY REP., *supra* note 3, at 25-26.

50. In New York, for example, legislation authorizes the creation of nonprofit nursing home companies. Such companies are eligible for tax exemptions, mortgage loan participation by the New York housing finance agency, and have access to special nursing home development funds. *See* N.Y. PUB. HEALTH LAW §§ 2864, 2866 (McKinney 1971).

51. For a description of nursing home abuses, see SUBCOMMITTEE ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, 93D CONG., 2D SESS., NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, SUPPORTING PAPER NO. 1, THE LITANY OF NURSING HOME ABUSES AND AN EXAMINATION OF THE ROOTS OF CONTROVERSY (Comm. Print 1974) [hereinafter cited as SUPPORTING PAPER NO. 1]. Nursing home ombudsmen projects funded by HEW have been established in Wisconsin, Massachusetts, South Carolina, Idaho, Oregon, Pennsylvania, and Michigan. These projects, designed to monitor nursing homes and to resolve patient problems, also are sources of information as to the type of abuses which occur in nursing homes. *See* INTRODUCTORY REP., *supra* note 3, at 100-02.

52. See text & note 10 *supra*; text & note 133 *infra*.

53. "The hard cold fact is that nursing homes suffer from the lack of medical care and supervision. What patient care there is, is given by nurses. In the end, 80 to 90 percent of the care is given by untrained aides and orderlies." SUBCOMMITTEE ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, 93D CONG., 2D SESS., NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, SUPPORTING PAPER NO. 3, DOCTORS IN NURSING HOMES: THE SHUNNED RESPONSIBILITY 320 (Comm. Print 1975) [hereinafter cited as SUPPORTING PAPER NO. 3]. This was strikingly illustrated by an investigation of the Better Government Association of Chicago. Using phony job references, investigators secured employment as mop boys, nurse's aids, and janitors. Within hours of beginning work, they were administering drugs and one was even serving as the administrator of a home. INTRODUCTORY REP., *supra* note 3, at 86.

records are maintained badly.[54] Doctors frequently ignore nursing home patients and are unavailable, even in emergencies.[55] As a result, medical conditions often are misdiagnosed and patients are treated improperly. Thus, it is not surprising that nursing home patients transferred to hospitals often are found to be comatose and severely dehydrated.[56]

In some nursing homes, patients are physically and verbally abused by untrained and insensitive personnel,[57] and in a large number of homes, patients simply are ignored.[58] This practice has a catastrophic effect upon the well-being of a patient who is struggling to cope with a diminished capacity to care for himself. Because requests for assistance to walk to the bathroom are ignored, incontinence results. Similar problems exist with respect to requests for assistance in other daily activities, such as dressing and bathing. Bedridden patients are not turned; bedsores develop and become infected. Bed pans are not provided, and patients must lie in their own wastes. Food is bad, bland, or cold, or assistance in eating is not provided.[59] Sometimes, food is spoiled or otherwise unwholesome.[60]

Patient privacy also is violated, and little consideration is given by nursing home staff to the effect of their actions upon patient dignity. For example, male and female patients are bathed together in spite of the extreme embarrassment this may cause the patients involved.[61] Patients are sedated or physically restrained, not for their own safety or well-being, but for staff convenience.[62] Patient property is lost or stolen. This is particularly disturbing when the disappearance of items such as eyeglasses or dentures leaves the patient helpless. Patient money that is entrusted with the home sometimes is not accounted for or returned.[63] Also, patients sometimes are charged for services not received, for services which were to be included in the basic charge,[64] or they are charged at artificially inflated prices. Another problem sometimes encountered is the refusal of some homes to take Black patients or Medicaid patients.[65]

54. *See* SUPPORTING PAPER No. 1, *supra* note 51, at 180-83.
55. Until medical schools and physicians take a more active interest in the elderly and nursing homes, it will be extremely difficult to improve the quality of the medical care provided. *See generally* SUPPORTING PAPER No. 3, *supra* note 53.
56. SUPPORTING PAPER No. 1, *supra* note 51, at 170.
57. *Id.* at 171-73.
58. *See* C. TOWNSEND, *supra* note 6, at 18. *See also* discussion note 128 *infra.*
59. SUPPORTING PAPER No. 1, *supra* note 51, at 176-80.
60. *Id.* at 173-74. For a discussion of the 1970 Baltimore salmonella epidemic, see C. TOWNSEND, *supra* note 6, at 71-80.
61. For a discussion of the general lack of bathing care, *see* SUPPORTING PAPER No. 1, *supra* note 51, at 196-99.
62. *Id.* at 188-91; see discussion note 124 *infra.*
63. SUPPORTING PAPER No. 1, *supra* note 51, at 180-83.
64. *Id.* at 199-204.
65. SUBCOMMITTEE ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING,

Patients also suffer as a result of Medicare and Medicaid regulations. First, regulations may limit the ability of patients to leave the home for short therapeutic visits, such as during holidays.[66] Second, Medicaid utilization review regulations, a cost control device designed to ensure that only patients truly needing health care receive it,[67] may adversely affect patients. Such reviews may result in a patient being transferred from the home to a distant community with little notice and without an effective opportunity to contest the proposed transfer,[68] or result in a refusal by Medicare to pay for the patient's care, without providing the patient with an opportunity to contest the decision.

Some homes defraud the government by obtaining unearned Medicare or Medicaid payments. Costs can be inflated artificially in many ways: increasing the salary of an operator without valid reason, creating salaried positions for friends or relatives who perform little or no actual service, overbilling for goods and services, overcounting patient bed days, or renting space or equipment at exorbitant rates from corporations which the operator actually controls. This practice is doubly destructive in states such as New York, which reimburse homes according to a cost-related formula. By increasing their costs, the homes pad their profits. Thorough auditing and strict enforcement of civil and criminal sanctions against fraud and misrepresentation are needed to control abuses of this sort.[69] If careful scrutiny does not occur, costs will increase without any improvement in patient care.

C. *Quality Standards*

Facilities participating in Medicare and Medicaid are governed by three separate standards of quality—federal regulations, standardized fire safety regulations known as the Life Safety Code [LSC], and state

93D CONG., 2D SESS., NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, SUPPORTING PAPER No. 8, ACCESS TO NURSING HOMES BY UNITED STATES MINORITIES (Comm. Print 1975). *See* INTRODUCTORY REP., *supra* note 3, at 10.

66. Payments for therapeutic home visits may be made up to 3 days per visit, with no more than two visits per calendar quarter and a total of six such visits per year. 45 C.F.R. § 250.30(d)(c)(2) (1974). Medicaid funds may be used to reserve bed space in an SNF or ICF if an individual has been temporarily hospitalized for an acute condition or if his physician has indicated, as part of the written plan of medical care, that therapeutic home visits are appropriate. These payments will be made only if the bed otherwise would have been occupied and if the patient intends to return to the facility. If a patient is hospitalized, payments will only continue for 15 days.

67. *See* text & notes 146-52 *infra.*

68. *See* text & notes 152-55 *infra.*

69. Morris Abram, chairman of a special New York state commission that is currently investigating the nursing home industry, has suggested that independent accountants be required to certify nursing home books "at the risk of their professional lives." N.Y. Times, Feb. 25, 1975, § L, at 38, col. 4. This suggestion was codified recently by S. 6545 (1975), *amending* N.Y. PUB. HEALTH LAW § 2807 (McKinney Supp. 1974-75). For a discussion of available civil sanctions, see text & notes 263-66 *infra.* For a discussion of criminal sanctions, see text & notes 282-86 *infra.*

standards. Those not participating in Medicare or Medicaid need only meet the standards established by the state in which they are located.[70]

1. *Federal Standards.* Federal standards imposed by the Social Security Act and regulations promulgated by HEW set forth the requirements that an SNF must meet to be eligible for reimbursement by Medicaid or Medicare. On January 17, 1974, these basic conditions of participation were issued in final form.[71] Some of these conditions govern patient care, including areas such as physician services,[72] nursing services,[73] dietetic services,[74] rehabilitative services,[75] and the development of an appropriate activities program for each patient.[76] Other conditions specify the codes and programs that must be met. This category requires compliance with licensing requirements of the state in which the SNF is located;[77] conformity with federal, state, and local laws relating to fire, safety, and sanitation;[78] compliance with LSC requirements;[79] enforcement of a utilization review plan;[80] and construction requirements.[81] Still other conditions relate to transfer agree-

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70. See discussion note 13 *supra.*

71. 20 C.F.R. §§ 405.1101-.1137 (1974).

72. *Id.* § 405.1123. Information about a patient's rehabilitation potential and a summary of prior treatment is to be made available within 48 hours of admission. To ascertain a patient's needs and develop a plan of care, a physical exam also is required within 48 hours of admission, unless one was conducted within 5 days preceding entry. For the first 90 days, a physician must see his patient at least once every 30 days. Thereafter, a physician is required only to see his patient once every 60 days.

73. *Id.* § 405.1124. A registered nurse [RN] must be employed as full-time director of nursing services. This director is responsible for developing the objectives, standards, and procedures for nursing care in the facility. The director also designates a charge nurse to be responsible for the supervision of nursing activities on each tour of duty. A facility must provide 24-hour nursing service and the personnel necessary to ensure that each patient receives the proper care, medications, and diet, and is kept clean, comfortable, and well-groomed.

74. *Id.* § 405.1125. A full-time dietetic supervisor is responsible for planning menus that both meet the medical nutritional needs of patients and, to the extent medically possible, comply with the requirements of the Food and Nutrition Board of the National Research Council National Academy of Sciences. Three meals, or their equivalent, are to be served and bedtime nourishment must also be provided. Foods are to be prepared in a manner which conserves flavor and appearance and are to be served at the proper temperature.

75. *Id.* § 405.1126. Qualified therapists are to provide the services that patients need to improve and to maintain functioning. These services are to be provided upon written order of the patient's physician.

76. *Id.* § 405.1131. An activities program is to be provided under the guidance of a qualified activities coordinator or a staff person in consultation with such coordinator. Meaningful activities are to be available to promote the physical, social, and mental well-being of the patients.

77. *Id.* § 405.1120.

78. *Id.*

79. *Id.* § 405.1134.

80. *Id.* § 405.1137 (1974). Each facility must have a written utilization review plan which has been approved by the governing body of the facility and the medical director. For a discussion of utilization review, see text & notes 146-52 *infra.*

81. 20 C.F.R. § 405.1134 (1974). Included are requirements relating to the design and location of nurses stations, toilet facilities, kitchen facilities, dining facilities, and the general environment.

ments with hospitals,[82] disclosure of ownership,[83] the establishment of an infection control committee,[84] and the provision of an effective governing body for the facility[85] so that the lines of legal authority and responsibility for the institution are clearly delineated and determinable. On October 3, 1974, HEW issued further regulations[86] which require SNF's to establish policies protecting the rights of patients,[87] appoint a medical director,[88] and provide a registered nurse [RN] 7 days a week.[89]

Regulations governing ICF's also were promulgated by HEW on January 17, 1974.[90] These include requirements relating to maintenance of a staff that is sufficiently large to discharge all of the duties in the facility and procedures relating to admission, transfer, and discharge of patients.[91] Additionally, an adequate transfer agreement with hospitals[92] and maintenance of a sufficient record keeping system to allow effective monitoring and review of a patient's condition are mandatory.[93] Compliance with conditions of the LSC[94] and other

82. *Id.* § 405.1133. A transfer agreement is a written agreement with a hospital which assures that it will promptly admit a patient from the SNF when medically appropriate.

83. *Id.* § 405.1121. The facility is required to furnish to the survey agency the names of anyone owning an interest of 10 percent or more in the SNF, or who holds, in whole or part, a mortgage secured by the SNF or its assets. In case an SNF is organized as a corporation, each officer and director must be revealed; if it is organized as a partnership, the identity of each partner must be revealed.

84. *Id.* § 405.1135. An infection control committee, composed of members of the medical, nursing, housekeeping, and other staffs, is charged with the duty of establishing policies and procedures to investigate, control, and prevent infections in the facility and to monitor performance.

85. *Id.* § 405.1121.

86. 39 Fed. Reg. 35774-78 (1974).

87. *Id.* at 35775. For a detailed discussion of patients' rights provisions, see text & notes 114-29 *infra.*

88. 39 Fed. Reg. 35776 (1974). A physician is to be retained to serve on a full or part-time basis as the medical director of a facility. To discharge his duty of coordinating medical care in the facility, he must develop written by-laws, rules and regulations, and a liaison with attending physicians. A facility is not required to retain a medical director until January 1976, however. Additionally, if the Secretary determined that a facility is located in an area where the supply of physicians is not sufficient to permit compliance with this requirement without seriously reducing the availability of physicians' services in the area, the requirement may be waived. *Id.* at 35777.

89. *Id.* at 35776-77. These services are to be provided at least during the day tour. The Secretary is authorized to waive the requirement of RN services in excess of 40 hours per week if the facility is in an area where the supply of skilled nursing services is not sufficient to meet local needs. Such a facility, however, must have an RN on duty at least 40 hours per week, have alternative arrangements to provide skilled nursing services for any patient during the 48 hour period when an RN is not on duty, and be continuing to make good faith efforts to comply with the more than 40 hour RN requirement. *Id.* at 35777.

90. 45 C.F.R. § 249.12 (1974).

91. *Id.* § 249.12(a)(1). The numbers and categories of personnel are determined by the number of residents and their particular needs in accordance with guidelines issued by the Social and Rehabilitation Service of HEW. The written policies pertinent to admission, transfer, discharge, and the type of services provided by a facility must be available to the staff, residents, and the public.

92. *Id.* § 249.12(a)(2).

93. *Id.* § 249.12(a)(4). The type of records which must be kept include admission information, initial and periodic examinations, an overall plan setting forth goals to be

structural standards also is required.[95] There are provisions regarding menu and patient diets;[96] governing health care, such as requirement that there be a written health care plan for each patient;[97] and provisions for nursing supervision.[98] There also are provisions for a resident administrator,[99] an activities program,[100] social services,[101] supportive rehabilitative services,[102] and physician services.[103]

The standards governing SNF's and ICF's have been criticized on at least two grounds. First, they are too flexible.[104] HEW contends that flexibility is desirable because it is unrealistic to impose precise standards because of the variety of institutional settings covered by the regulations and that enforcement will be unwieldy if specific standards are created.[105] In contrast, critics charge that lack of specificity deprives enforcement agencies and patients of meaningful measures of compliance and enables homes to provide inadequate care.[106] Unless standards are precise, neither the enforcement agency nor the facility have an adequate basis for determining compliance with the regulations. Moreover, delays in enforcement are likely to result from disputes over the meaning of the standards. Similarly, imprecision de-

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accomplished, information as to treatment, services and medications received, and information as to symptoms displayed and the response taken.

94. *Id.* § 249.12(a)(5). Under certain circumstances compliance with this requirement may be waived. For further discussion, see text & notes 203-06 *infra.*

95. 45 C.F.R. § 249.12(a)(6) (1974). This provision notes location and size requirements for some rooms and states that areas for dining, social activities, and therapy shall be provided.

96. *Id.* § 249.12(a)(7). The requirements are similar to those imposed on SNF's. *See* discussion note 74 *supra.*

97. 45 C.F.R. § 249.12(a)(9) (1974). The written health care plan is to be implemented in accordance with instructions of the attending or staff physician. The plan is to be renewed at least every 3 months.

98. *Id.*

99. *Id.* § 249.12(b)(1)(2). The facility is to be administered by a person licensed as a nursing home administrator. This individual, or another person on the professional staff of a facility, is responsible for coordinating and monitoring the overall care plan of the residents.

100. *Id.* § 249.12(b)(5).

101. *Id.* § 249.12(b)(4). The facility is to provide or arrange for social services "as needed." This provision places a flexible duty on the facility. Unless it is determined that social services are needed to promote preservation of a resident's physical and mental health, they need not be provided.

102. *Id.* § 249.12(b)(3).

103. *Id.* § 249.12(b)(6). The attending physician must see his patient at least once every 60 days, unless otherwise justified and documented.

104. Regulations are inadequate where "virtually all the specifics are deleted in the name of flexibility. This lack of specificity (or excess flexibility) makes the standards impossible to enforce. Unhappily, the result will be deterioration in the quality of care." INTRODUCTORY REP., *supra* note 3, at 53.

105. An example of this criticized flexibility is the failure of the regulations to impose patient-staff ratios. Instead, facilities are required only to provide "twenty-four hour nursing service which is sufficient to meet nursing needs." 20 C.F.R. § 405.1124 (c) (1974). HEW views the creation of minimum patient-staff ratios as providing "false benchmark[s]." INTRODUCTORY REP., *supra* note 3, at 49.

106. During hearings before the Senate Subcommittee on Long-Term Care on October 10-11, 1973, criticisms were directed at the proposed standards for homes. *Hearings on Trends in Long-Term Care Before the Subcomm. on Long-Term Care of the Senate Special Comm. on Aging,* 93d Cong., 1st Sess., pts. 21-22 (1973).

prives patients of a measure on which to base tort liability where the home is charged with providing inadequate care.

The regulations also are criticized for failing to include certain requirements regarded as vital to adequate patient care.[107] Initially, SNF's were required to have an RN on duty only 5 days a week.[108] This was amended so that RN's now are required 7 days a week, but a waiver may be obtained if nurses are unavailable.[109] Although a medical director for SNF's is required by regulation, implementation of this requirement has been delayed.[110] Also, doctors now are required to visit only every 60 days, whereas under earlier regulations visits every 30 days were required.[111] In addition, the failure to require SNF's to have a social worker on their staff has been criticized.[112] Similar criticisms have been leveled at the ICF regulations.[113]

Consumer criticism has had some effect, particularly in the area of patient rights. As originally proposed, the SNF regulations contained no provisions regarding the rights of patients. Criticism of this omission prompted HEW to propose new regulations requiring SNF's to establish policies guaranteeing patients certain basic rights.[114] One major group of rights is designed to ensure that the patient is informed of actions affecting him. Thus, the facility is required to inform the patient of his rights[115] and the charges for services.[116] Medical information about the patient's condition and the proposed treatment must be disclosed to him unless a physician has noted it is medically inadvisable.[117] In addition, a patient is entitled to manage his personal finan-

107. *Id.*
108. 39 Fed. Reg. 2244 (1974).
109. *See* discussion note 89 *supra.*
110. *See* discussion note 88 *supra.*
111. 20 C.F.R. § 405.1123(b) (1974). The previous requirement of visits every 30 days was initially modified by interim standards promulgated on July 12, 1973, which noted that although monthly visits were required for the first 90 days, thereafter the physician could work out an alternate schedule of visits at his discretion. 38 Fed. Reg. 18624 (1973).
112. As a result of Pub. L. No. 92-603, § 265, 86 Stat. 1450 *amending* 42 U.S.C. § 1395x(j)(15) (1970) (codified at 42 U.S.C. § 1395x(j)(15) (Supp. II, 1972)), a requirement of medical social services is no longer a condition of participation. *See also* 20 C.F.R. § 405.1130 (1974).
113. *See* INTRODUCTORY REP., *supra* note 3, at 54.
114. On January 17, 1974, HEW first noted that commenters on proposed new standards for SNF's had indicated an interest in securing a bill of rights for patients. The department indicated that proposed rules would be published at a later date and invited comment at such time. 39 Fed. Reg. 2238 (1974). Four months later, the proposed rule appeared as a new condition of participation for SNF's. 39 Fed. Reg. 15230 (1974). Comments were received and evaluated before the final version was adopted in October of 1974. 20 C.F.R. § 405.1121(k) (1974).
The regulations presently apply only to SNF's. A proposed regulation would extend similar rights to all residents of ICF's participating in Medicaid, and thus provide a uniform HEW policy regarding patients' rights. 40 Fed. Reg. 8956 (1975).
115. 20 C.F.R. § 405.1121(k)(1) (1974).
116. *Id.* § 405.1121(k)(2).
117. *Id.* § 405.1121(k)(3).

cial affairs and to receive a quarterly accounting from the facility for any personal funds it controls.[118]

Another group of regulations is designed to reduce the atmosphere of dependency and intimidation which pervades many homes. Nursing home residents are extremely vulnerable and retaliation is a genuine source of concern. Retaliation can be effected subtly—not responding promptly to calls for assistance or serving cold food—or overtly—demanding that the patient leave the home. Fear of retaliation is directly responsible for the low number of complaints originating from residents[119] and is often cited by families as a reason why they do not complain about nursing home conditions.[120] Until the coercive atmosphere now present in many homes is dissipated, complaints will continue to be stifled. In an attempt to rectify this situation, these regulations provide that patients are entitled to complain about the facility,[121] to communicate freely with persons within and without the facility, and to participate in religious services of their choice.[122] Further, the regulations limit the power of the facility to transfer patients for nonmedical reasons.[123]

118. *Id.* § 405.1121(k)(6). In many institutions patients depend on the institution to control and distribute small personal allowances. Often, however, accounting records are maintained carelessly and patient monies are wrongly intermingled with institutional funds. *See* PENNSYLVANIA NURSING HOME OMBUDSMAN PROJECT FINAL REPORT 4-5 (July 1, 1972-June 30, 1974). In addition, residents are sometimes overcharged for "extra" services, such as hair care. For comments about theft in general and failure of the facility to allot personal allowances to patients, see SUPPORTING PAPER NO. 1, *supra* note 51, at 180-82. The new regulation, designed to end these abuses, would require monthly reports.

119. A number of examples of reprisals against nursing home patients are found in SUPPORTING PAPER NO. 1, *supra* note 51, at 191-93. In some instances complaints about inadequate conditions led to "more coldness and neglect." When one patient's family complained because the patient had been left lying helpless on the floor for 3 hours after falling down, the facility required the family to relocate the patient because he was a "management" problem. *Id.* at 192-93. In an even more extreme case, a nursing home administrator and nurse's aid were convicted of the murder of a patient. The patient had threatened to reveal that checks were being forged in his name. *Id.* at 172.

120. Fear of retaliation has affected the number of complaints received by workers in nursing home ombudsman projects. *See* MASSACHUSETTS NURSING HOME OMBUDSMAN PROJECT, 6TH QUARTERLY REPORT 19 (1974); MICHIGAN NURSING HOME OMBUDSMAN PROJECT REPORT (June 1973-Nov. 1974); PENNSYLVANIA NURSING HOME OMBUDSMAN PROJECT FINAL REPORT, *supra* note 118, at 18.

121. *See* 20 C.F.R. § 405.1121(k)(11) (1974). A regulation issued by the Pennsylvania Department of Public Welfare should also be considered by HEW. It explicitly grants outsiders, such as lawyers, social workers, and community organizations the right to enter the nursing home. *See* 4 HEALTH LAW PROJECT, U. PA. LAW SCHOOL, MATERIALS ON NURSING HOMES 185-88 (rev. ed. 1972). For a discussion of the problem generally, see Health Law Project, U. Pa. Law School, *Legal Problems Inherent in Organizing Nursing Home Occupants*, 6 CLEARINGHOUSE REV. 203 (Aug. 1972).

122. 20 C.F.R. § 405.1121(k)(12) (1974). Subsections 11 and 12 evidence a clear intent for the patient to continue normal activities and interests. The patient should be permitted free access to the use of a telephone, for example, as provided in the proposed Massachusetts bill. *See generally* discussion note 128 *infra*. The encouragement of activity may help reduce the attitude of infantilism with which many staffs treat patients and reduce the feeling of residents that their lives are empty and meaningless. The importance of the patient's ability to express grievances about his environment without fear of retaliation cannot be overstated.

123. 20 C.F.R. § 405.1121(k)(4) (1974). Perhaps most traumatic for the patient

The regulations also contain explicit guarantees of the right to be free of physical and mental abuse and from physical and chemical restraints, except where necessary.[124] Other areas covered are rights of privacy[125] and freedom from involuntary servitude.[126] The regulations require that patients and the public be made aware of the facility's policies regarding patients' rights and that the facility's staff be trained to implement the policies.[127]

While criticism has resulted in some improvements, it is clear that the regulations could be more comprehensive. Substantive omissions and the lack of an adequate enforcement structure weaken their effectiveness. For example, the facility is not required to designate a representative to receive complaints nor is it required to record complaints

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is the institution's ability to transfer or discharge a patient arbitrarily. The new section permits transfer or discharge "only for medical reasons, or for his welfare or that of other patients, or for nonpayment for his stay," and requires that the resident be "given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his medical record." This section is intended to reduce retaliatory transfers, but its effectiveness may be limited because there is no adequate procedure to prevent such transfers. Additionally, new regulations should specifically prohibit *any* retaliatory action by the nursing home, not just retaliatory transfer. By way of comparison, the defense of "retaliatory eviction" in the landlord-tenant law has been recognized in an increasing number of jurisdictions, on statutory as well as constitutional grounds. *See* McQueen v. Druker, 438 F.2d 781 (1st Cir. 1971); Edwards v. Habib, 397 F.2d 687 (D.C. Cir. 1968), *cert. denied*, 393 U.S. 1016 (1969); Hosey v. Club Van Cortlandt, 299 F. Supp. 501 (S.D.N.Y. 1969); ARIZ. REV. STAT. ANN. § 33-1381 (1974); CAL. CIV. CODE § 1942.5 (West Supp. 1975). For a discussion of the development of the case law of retaliatory eviction and a collection of relevant statutes, see *Developments in Contemporary Landlord-Tenant Law: An Annotated Bibliography*, 26 VAND. L. REV. 689, 707-716 (1973); CCH POV. L. REP. ¶ 2325 (1972). *See also* Note, *Landlord-Tenant Reform: Arizona's Version of the Uniform Act*, 16 ARIZ. L. REV. 79, 130-35 (1974).

124. 20 C.F.R. § 405.1121(k)(7) (1974). Subsection 7 could be a powerful device against unwanted external control if vigorously enforced. Because patient sedation and restraint can be abused so easily, vigorous enforcement will be necessary. SUPPORTING PAPER NO. 1, *supra* note 51, at 189, notes that "the use of restraints is an admission of failure of the nursing process." The committee received numerous reports of patients who were tied up for long periods of time without medical supervision, for the simple reason that restrained patients were easier to supervise. Subsection 7 is still deficient in that it allows some sedation or restraint in non-emergency situations and because it fails to require periodic checks of restrained patients. Arizona, Idaho, Indiana, Pennsylvania, and Wisconsin require restrained patients to be checked every hour, while Maine requires supervision every half hour. Alabama, Delaware, Illinois, Maryland, New Jersey, and Tennessee provide that a patient may not be restrained for longer than 24 hours at a time. For a list of state statutes, see NURSING HOME LAW MANUAL, *supra* note 42, *Consents*.

125. 20 C.F.R. § 405.1121(k)(9) (1974).

126. *Id.* § 405.1121(k)(10). The right of institutionalized persons to receive the minimum wage, although not clearly established, has been argued on three separate grounds: the Fair Labor Standards Act [FLSA], 29 U.S.C. §§ 201-219 (1970), *as amended*, 29 U.S.C.A. §§ 202-204, 206-208, 210, 212-214, 216 (Supp. 1975), the 13th amendment, and the constitutional right to treatment. *See* Friedman, *The Mentally Handicapped Citizen and Institutional Labor*, 87 HARV. L. REV. 567, 571-86 (1974). One court has concluded that the FLSA does require compensation for institution-maintaining labor, even if it is therapeutic. *See* Souder v. Brennan, 367 F. Supp. 808 (D.D.C. 1973). Some courts, however, have ruled that it is constitutionally permissible to charge patients for the reasonable cost of room, board, and treatment. *See* Wiginton v. State Home & Training School, 175 Colo. 159, 486 P.2d 417 (1971); State v. Kosiorek, 5 Conn. Cir. 542, 259 A.2d 151 (App. Div. 1969); Department of Mental Health v. Coty, 38 Ill. 602, 232 N.E.2d 686 (1967).

127. 20 C.F.R. § 405.1121(k) (1974).

and their disposition. One omission which must be corrected is the failure to require that patient requests for assistance be responded to promptly.[128] State agencies must ensure that the regulations are implemented. Patients, their friends, and families should be encouraged to report violations of rights, and noncomplying facilities should be dealt with severely. In addition, in view of the difficulty of monitoring compliance, a private cause of action should be created explicitly authorizing patients to sue where their rights are violated.[129] The predominant position occupied by the nursing home industry in state and federal policy making[130] is, however, a barrier to the development of more comprehensive regulations. Industry associations have worked very hard to influence the shape of nursing home regulations and have been quite successful in obtaining access to HEW.[131] Their opposition to proposed changes in nursing home regulations is difficult to overcome.

2. *Life Safety Code [LSC].* The LSC, developed by the National Fire Protection Association, contains requirements affecting the physical structure of a facility.[132] These standards, applicable to all institu-

128. Both Maryland law and a proposed Massachusetts bill of rights contain an important provision not found in the federal regulations: the right of prompt response to patient requests. The Maryland statute states that every resident "shall have the right to expect the facility to make a reasonable response to [his] requests." MD. ANN. CODE art. 43, § 565(c)(1)(6) (Supp. 1974). The proposed Massachusetts bill includes "the right to have all reasonable requests and inquiries responded to promptly and adequately within the capacity of the facility." House No. 141 (1975). Prompt response to requests is extremely important and the federal regulations should be amended to include such a provision.

In the federal regulatory scheme, the nursing facility is required to have a nurses' call system. 20 C.F.R. § 405.1134 (1974). One commentator has noted that: "If a home has a call system, it must make certain that all employees are aware the patients' calls must be answered within a reasonably short time, since failure to answer a call which results in injury may lead to liability." NURSING HOME LAW MANUAL, *supra* note 42, *Negligence* ¶ 2-2, at 13-14. Patient injury directly caused by a failure to respond has resulted in tort liability. *See* Jefferson Hosp. v. Van-Lear, 186 Va. 74, 41 S.E.2d 441 (1947). In *Jefferson,* an elderly cataract patient who had illuminated the call button for between 20-30 minutes, with no response, was allowed damages for injury sustained while attempting to wait on himself. The hospital was held to be negligent in not answering his call when it knew of his condition.

129. A patients' bill of rights, enacted by Maryland in 1974, provides that the new rights are not to be construed to restrict any other rights at law. MD. ANN. CODE art. 43, § 565C(c) (Supp. 1974). A proposed Massachusetts bill of rights provides that, in addition to any action allowed at law, a patient may bring a civil action in the superior court against the facility or an employee to prevent a violation and to recover damages from a violation that has occurred. House No. 141, subpart (x) (1975).

130. *See* INTRODUCTORY REP., *supra* note 3, at 84; N.Y. Times, Feb. 25, 1975, § 1, at 1, col. 2.

131. HEW has confirmed that drafts of nursing home regulations were leaked to the nursing home industry prior to publication. *See* INTRODUCTORY REP., *supra* note 3, at 49. *See generally* C. TOWNSEND, *supra* note 6; 118 CONG. REC. 1376 (1974) (speech by Arthur Jarvis, director of hospital and medical care for the state of Connecticut).

132. 42 U.S.C. § 1395x(j)(13) (Supp. II, 1972) requires SNF's to meet such provisions of the LIFE SAFETY CODE OF THE NATIONAL FIRE PREVENTION ASSOCIATION (21st ed. 1967) [hereinafted cited as LSC], as are applicable to nursing homes. *See also* 20 C.F.R. § 405.1134 (1974). An ICF must meet such "standards of safety and sanitation" as are established by the regulations of the Secretary. 42 U.S.C. § 1396d(c) (Supp. II, 1972), *as amended,* (Supp. III, 1973). For facilities of 15 beds or less, however, an ICF may need to meet only the requirements of the LSC that pertain to lodg-

tions, not just to nursing homes, are designed to minimize the risk of fire, a considerable hazard in nursing homes. The code's requirements govern fire alarm systems, sprinkler systems, the flammability of the structure, fire escapes, fire doors, and similar safeguards. Facilities are required to comply with the LSC to be eligible for Medicare and Medicaid reimbursement, but in spite of this requirement more than half of the homes fail to comply.[133]

3. *State Standards.* SNF's participating in Medicaid and Medicare are required to meet state standards as well as the federal standards and the LSC.[134] New York's standards[135] are representative although perhaps more comprehensive than those of other states.[136] All medical facilities must apply for an operating certificate or license before opening. These licenses are for a specific term so that a facility is required to renew the certificate periodically.[137] The State Commissioner of Health is given the authority to inspect facilities and their records, and to require reports to enable him to evaluate facilities seeking certificates.[138] New York has issued regulations governing

ing or rooming houses. 45 C.F.R. § 249.12(a)(5) (1974). *See* discussion note 203 *infra.*

133. Statistics on enforcement of LSC requirements for the period June-September 1973 revealed that:

—59 percent of the SNF's were certified with deficiencies. Of these 27.8 percent had incompleted plans or no plans of correction on file.
—29 percent of the SNF's were certified with waivers. Of these 21 percent had incomplete or no justification for waivers.
—4.2 percent of the SNF's were certified although the state fire authority indicated that LSC requirements were not met.
—8.7 percent of the SNF's had no LSC survey on file.
—50 percent of the SNF's required automatic sprinkler protection. Of these, 36.5 percent had no such protection.

OFFICE OF NURSING HOME AFFAIRS OF THE DEP'T OF HEW, ENFORCEMENT OF LIFE SAFETY CODE REQUIREMENTS IN SKILLED NURSING FACILITIES (1974).

134. Facilities are to be licensed by the state or fully meet standards established for such licensing. 42 U.S.C. § 1395x(j)(9) (1970), *as amended*, (Supp. II, 1972); 20 C.F.R. § 405.1120 (1974). Note that 20 C.F.R. § 405.1120(c) (1974) specifically requires compliance with state and local fire and safety laws, sanitation laws, and other relevant health and safety requirements.

Medicare or Medicaid funds may not be utilized to reimburse facilities which provide only domiciliary care. *See* discussion note 13 *supra.* Although these facilities are thus not required to meet federal standards, they must comply with applicable state standards and licensing procedures. State standards are frequently inadequate, however.

135. N.Y. PUB. HEALTH LAW §§ 2800-2809 (McKinney 1971). New York's provisions set up standards for "health related facilities," the state's term for an ICF. The federal statutory definition of an ICF indicates that the institution must be licensed by the state. 42 U.S.C. § 1396d(c) (Supp. II, 1972). Impliedly, therefore, it must meet whatever requirements a state imposes as preconditions to the granting of a license. HEW regulations further require that an ICF meet "Federal, State, and local laws, codes and regulations pertaining to health and safety." 45 C.F.R. § 249.12(a)(1)(vii) (1974). For examples of state standards which relate to ICF's, see 10 N.Y.C.R.R. § 714 (1975) (construction requirements); *id.* § 740 (operational requirements relating to admission of patients and confidentiality of records).

136. *See* N.Y. PUB. HEALTH LAW, art. 28 (McKinney 1971); 10 N.Y.C.R.R. § 700-782 (1975). The New York regulations also provide that medical facilities which receive operating certificates must comply with pertinent federal laws and regulations in addition to state and local laws and regulations. *Id.* § 700.3.

137. 10 N.Y.C.R.R. § 701.1 (1975).

138. *Id.* § 700.4.

fire and safety standards, compelling sprinkler systems, alarm devices, fire drills, and the proper handling of flammable liquids and gases.[139] Infection control and reporting standards require development of procedures to isolate patients with communicable diseases and reports of the existence of certain diseases to public health officers.[140] The regulations also control construction of nursing homes[141] and require disclosure of ownership.[142] Other regulations govern the provision of linen and laundry,[143] admission of patients, patient services, patient rights, and require confidentiality of records.[144]

New York also regulates the content of service agreements entered into between the patient and the nursing home, requiring, for example, that all services be listed and all charges specified and that certain minimum services be provided.[145] Federal regulations do not contain a comparable provision and would be strengthened by requiring a service agreement between facility and patient. The regulation should compel disclosure of all charges and ensure that specified services will be rendered and that the conditions of participation, specifically including a patient's bill of rights, will be met. A regulation of this nature would enhance enforcement efforts. Additionally, it would create a contractual relationship between the patient and the facility, and if the facility failed to comply with any of the conditions, a private action for breach of contract would lie.

D. *Standards of Patient Eligibility*

In addition to the standards required of nursing care facilities, only individuals needing the level of care provided by that facility are eligible for Medicare and Medicaid reimbursement. The rationale for this rule is that costs will be reduced and needed beds freed if patients are in the most appropriate medical setting. The rule is enforced by a procedure known as utilization review, under which a patient's continuing need for the facility's services is reviewed periodically.[146] Each

139. *Id.* § 702.3.
140. *Id.* § 702.4.
141. *Id.* § 713.
142. *Id.* § 620.1. This regulation provides that no person may own 10 percent or more of the stock in a facility unless such ownership is approved by the Public Health Council. The transfer or assignment of stock which results in the control by any individual of greater than 10 percent needs the approval of the Council. Section 620.2 requires disclosure of ownership percentages and the character of individuals where a sole proprietor or partnership seeks Public Health Council approval of ownership transfer.
143. *Id.* § 702.5.
144. *Id.* § 730.
145. *Id.* § 730.2. HUD has promulgated regulations which require local housing authorities to include lease provisions assuring compliance with HUD regulations and with local codes affecting health and safety. The HUD regulations also prohibit inclusion of exculpatory clauses and jury trial waivers. 39 Fed. Reg. 39285 (1974).
146. The federal government is authorized to reduce its level of assistance by one-

facility must have a utilization review committee composed of at least two doctors, plus other professional personnel,[147] and the committee reviews patient records in consultation with the attending physician.[148] Under Medicare, the utilization review committee's decision is forwarded to the fiscal intermediary. If the intermediary concludes that the patient does not need that level of care, the intermediary notifies the facility that care will not be reimbursed.[149] Similarly, under Medicaid, the facility is required to notify the state administering agency of any utilization review decision that continued services are not needed.[150] If alternative arrangements for the patient are not completed promptly, the federal reimbursement will be reduced.[151]

While utilization review is justifiable from the perspective of cost control, its consequences for the patient can be severe. A negative utilization review decision can result in the patient being transferred to a distant facility with little notice and no opportunity for a hearing to contest the determination. Under Medicare, the decision of a facility's utilization review committee is not reviewable.[152] Only the decision of the fiscal intermediary not to reimburse can be appealed, and this decision may not occur for some time after the utilization review decision. Thus, the patient and his family lack an effective vehicle for contesting the decision under the existing statutory scheme. This sys-

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third to any state that fails to implement an effective utilization review system for Medicaid. 42 U.S.C. § 1396b(g) (Supp. II, 1972), *as amended*, (Supp. III, 1973). Requirements of a utilization review plan for Medicare are set forth at 42 U.S.C. § 1395x(k) (1970), *as amended*, (Supp. II, 1972) and 20 C.F.R. § 405.1137 (1974). Section 405.1137(i) provides that if the Secretary determines that Medicaid utilization procedures are superior to the Medicare procedures, the former should be utilized. A Medicaid utilization review plan must meet at least the Medicare plan requirements of 42 U.S.C. §§ 1395x(k) (1970), *as amended*, (Supp. II, 1972); 42 U.S.C. § 1396b(i)(4) (Supp. II, 1972); and 45 C.F.R. § 250.19 (1974).

147. 20 C.F.R. § 405.1137(b)(1) (1974) (Medicare); 45 C.F.R. § 250.19(a)(1)(ii)(A) (1974) (Medicaid).

148. In the Medicare program, if the committee feels that admission or further stay is not necessary, the attending physician must be given an opportunity to present his views. 20 C.F.R. § 405.1137(e)(2) (1974). Under Medicaid, an attending physician is to be given an opportunity to present his views when the committee feels that an admission is not medically necessary, 45 C.F.R. § 250.19(a)(1)(viii)(D) (1974), or when the committee feels that further stay is not required. *Id.* § 250.19(a)(1)(x)(F).

149. 20 C.F.R. § 405.1803 (1974). After analyzing the provider's cost report, the intermediary informs the provider in writing of what will be reimbursed and gives an appropriate explanation for the decision.

150. 45 C.F.R. §§ 250.19(a)(1)(x)(G)(3), 250.19(a)(1)(x)(H)(3) (1974). The state agency is also notified when the committee determines that admission is not medically necessary. *Id.* §§ 250.19(a)(1)(viii)(E)(3), 250.19(a)(1)(viii)(F)(3).

151. See discussion note 146 *supra*. States have developed various procedures to effectuate this process. *See, e.g.* 18 N.Y.C.R.R. § 505.4(d)(6) (1975).

152. [1974 Transfer Binder] CCH MEDICARE-MEDICAID GUIDE ¶ 12,790. No appeal is allowed at this time because the committee's findings are not a determination of an intermediary or of the SSA, but are only evidence. At this point, a patient is placed in a dilemma if he feels further care is required. He must either leave the facility or remain and hope that the intermediary subsequently will disagree with the committee's findings or that he can win on an appeal to the SSA. If he loses, Medicare will not cover the costs of services, and he may be liable personally.

tem may be vulnerable to constitutional attack. In *Martinez v. Richardson*,[153] the denial of home health benefits under Medicare without adequate notice and a hearing was held to violate the due process requirements of the fifth amendment. The court found that the principles enunciated in *Goldberg v. Kelly*,[154] requiring notice and a hearing before welfare benefits could be withdrawn, were applicable.

Under Medicaid, an unfavorable utilization review decision should result in a timely notice to the patient from the department of social services of its intention to transfer him. The patient is entitled to challenge the proposed transfer at a fair hearing, but because current HEW regulations do not require that a nursing home resident be given advance notice of the proposed action, his ability to contest the transfer may be limited.[155]

II. PUBLIC ENFORCEMENT DEVICES

A. *Inspection and Certification*

1. *The Inspection Process.* Under Medicaid and Medicare, inspections for compliance with federal standards are conducted by an agency of the state, either the single state agency responsible for Medicaid administration or another agency to which this responsibility has been delegated.[156] In New York, inspections are performed by the New York State Department of Health under agreement with the State Department of Social Services, the state's designated single agency. The inspection process begins about 90 days before the end of the

153. 472 F.2d 1121 (10th Cir. 1973).

154. 397 U.S. 254 (1970).

155. 45 C.F.R. § 205.10 (1974) requires a system of hearings as a necessary part of a state Medicaid plan. Section 205.10(a)(4)(i) provides that whenever action is contemplated to "discontinue, terminate, suspend or reduce assistance," an individual must receive sufficient notice. In some situations, including when an individual is in a nursing home, the regulations require only that the notice be "adequate." This requirement is satisfied if notice is sent on the date of the action. *Id.* § 205.10(a)(4)(ii). It is not necessary that the notice be "timely," a requirement that is satisfied only if notice is given at least 10 days prior to the action. *See id.* § 205.10(a)(4)(i). In this situation the ability of the individual to effectively assert his rights is diminished. This may violate the requirements of Goldberg v. Kelly, 397 U.S. 254 (1970). *See* text accompanying notes 153-54 *supra*. For a discussion of this problem, see The Nat'l Health Law Program, *Transfer of Nursing Home Patients Requires Prior Notice and Hearing*, 7 CLEARINGHOUSE REV. 663 (1974); 7 CLEARINGHOUSE REV. 731 (1974).

156. The agency which is to make Medicare inspections is designated at 42 U.S.C. § 1395aa(a) (1970), *as amended*, (Supp. II, 1972). This same agency will generally be utilized for Medicaid inspections. *See id.* § 1396(a)(33)(B).

HEW reimburses the states for 100 percent of the costs attributable to compensation and training of state agency personnel "responsible for inspecting public or private institutions . . . providing long-term care to recipients of medical assistance to determine whether such institutions comply with health or safety standards applicable to such institutions . . . ." 42 U.S.C. § 1396b(a)(4) (Supp. II, 1972), *as amended*, (Supp. III, 1973). In 1972 and 1973, HEW trained 2,000 state nursing home inspectors at a cost of $1.2 million. INTRODUCTORY REP., *supra* note 3, at 95.

provider agreement[157] so that results are available prior to expiration. The review includes inspection of both fire safety and health conditions.[158] Until recently, visits were announced to the facility sufficiently ahead of time to allow them to gather records and to ensure that the necessary personnel would be present.[159] The inspection staff typically is composed of a doctor, a hospital administrator, a nurse, a sanitation expert, a nutritionist, and an engineer who are each responsible for evaluating different aspects of a facility. Other experts, such as pharmacists, occupational therapists, and civil rights compliance specialists are also available.[160] In general, the entire inspection team visits the facility at the same time in order to evaluate accurately the total environment of the institution. Upon completion of the survey, the inspection team holds exit interviews with their counterparts at the facility.[161] A report describing all deficiencies is prepared and sent to the facility which is required to submit to the agency an acceptable plan of correction detailing how and when corrective measures will be taken. The report and the plan of correction are forwarded to the agency's headquarters with recommendations regarding certification action. Depending on whether the survey is conducted for Medicaid or Medicare, the state agency either decides whether to certify the facility or to forward the survey material to HEW with its recommendations.[162]

Inspections for compliance with state standards are conducted in the same way, usually at the same time. In general, a facility complying with federal regulations also will be in compliance with state standards. Where state standards are more stringent, however, a violation of the state standard will be noted and processed for compliance. Ordinarily, inspections occur only once each year, except that follow-up inspections are done to ensure that deficiencies discovered during the annual survey have been corrected.

Although this process results in the correction of some violations,

157. For information concerning the terms of a provider agreement, see text & notes 180-81 *infra.*

158. DEPARTMENT OF HEW, REGIONAL DIRECTOR'S LONG TERM CARE MANUAL, LTC-1, § 2000 [hereinafter cited as MANUAL].

159. See text & notes 171-73 *infra.*

160. The inspection team for the central New York State area consists of two physicians, one supervising nurse, nine staff nurses, four sanitation experts, three social workers, three nutritionists, one physical therapist, two hospital administrators, and one civil rights Title VII compliance inspector. Pharmacy consultants and other experts are available. Such individuals are drawn from the team as are necessary to inspect a given facility. This team is responsible for inspecting 88 SNF's, 15 to 20 ICF's, 40 hospitals, and 45 clinics. Interview with Dr. Frank Furth, Regional Office of the New York Dep't of Health, in Syracuse, N.Y., January, 1975.

161. Within 90 days of the completion of the survey, the Secretary is required to make public, in a readily available form and place, the pertinent findings of the survey team. 42 U.S.C. § 1395aa(a) (1970), *as amended,* (Supp. II, 1972). *See* discussion note 169 *infra.*

162. *See* text & notes 182-85, 194 *infra.*

many serious violations are not detected. Further, information as to deficiencies found during inspections is not widely distributed; thus the public remains ignorant of which facilities contain deficiencies and which do not. In short, while the continued existence of serious problems is not entirely the fault of the inspection process, improvements in that process would substantially reduce the number of problems.

Some of the problems arise because of the nature of the inspection staff. Enforcement agencies often are understaffed. Because of staff vacancies, inspection teams sent to institutions sometimes lack critical members, such as doctors and hospital administrators. Also, because of other responsibilities, nursing home inspections are assigned low priority with the result that follow-up inspections may not occur or complaints may not be responded to. Sometimes the integrity of the process is compromised. Inspectors are bribed or are told to stifle adverse informaton by supervisors.[163] Inspectors also may be reluctant to cite a nursing home out of a concern for the consequences to the home. These problems can only be corrected if enforcement staffs are well staffed with highly trained, independent, and motivated professionals. At present they are not, and nursing home patients have suffered as a result.

Another problem is that inspections usually are undertaken only for the purpose of annual certification, rather than for the purpose of investigating complaints.[164] Enforcement agencies should publicize their existence and should invite public complaints concerning conditions in nursing homes.[165] These complaints should be responded to, promptly resolved, and the results conveyed to the complainant. A complaint orientation would enable the agency to learn of and respond to a variety of pressing problems better than it can under the existing system. The establishment of a complaint center would require a commitment of additional staff for it is clear that existing staffs are inadequate to carry out their current responsibilities, much less assume this additional burden.

The value of inspections also would be increased if a greater effort were made to elicit patient and staff views during nursing home inspec-

163. INTRODUCTORY REP., *supra* note 3, at 80.

164. Although housing code enforcement agencies have investigated tenant initiated complaints with generally good results, the agency must be able to respond adequately if the system is to work; otherwise its credibility is undermined. *See* Teitz & Rosenthal, *Housing Code Enforcement in New York City, reprinted in* D. MANDELKER AND R. MONTGOMERY, HOUSING IN AMERICA 480-89 (1973).

165. New York has recently instituted a Hotline program. Administrators of nursing homes are required to post notices describing this program and providing the Hotline phone number, which will connect the caller with a special patient's advocate at the closest regional office of the state health department. The patient's advocate will then initiate an investigation into the complaint and act to correct the problem. N.Y. State Dep't of Health News Release (Jan. 24, 1975).

tions. The views of patients and dissident staff members elicited during hospital inspections by the Joint Commission for the Accreditation of Hospitals have led to improvements in general hospitals in the District of Columbia, Chicago, and elsewhere.[166] Nursing home inspectors should seek out these views, confidentially if necessary, and should more carefully review patient treatment records to ascertain whether proper treatment is being provided by the home and attending physician.

Wide circulation of inspection results also is important. The public, including patients and their families, generally are not told of deficiencies discovered during inspections. Enforcement agencies should publicize inspection results to induce prompt compliance and to inform the public of quality differences among homes. The results of restaurant inspections, for example, often are announced and printed in daily newspapers. The same practice should be followed for nursing home inspections.[167] Inspections results should be posted in the facility for patients and the public to view, and facilities should be required to maintain for public inspection the findings of all inspections for the preceding 5 years. This process would be enhanced by the establishment of a rating system under which the enforcement agency would grade facilities according to the quality of care they provided. The information currently available to the public is inadequate. As a result of the Social Security Amendments of 1972[168] and of several cases,[169] the pub-

166. Although the Commission did not readily agree to hear these groups, their views were presented. *See* Worthington & Silver, *Regulation of Quality of Care in Hospitals: The Need for Change*, 35 LAW & CONTEMP. PROB. 305 (1970).

167. Currently, summaries of New York nursing home inspections are available for public review at local Department of Social Services offices for a Medicaid survey and at the Social Security district offices for a Medicare survey. A recent release from the New York Department of Health expressed the intention to compel wider disclosure. New York now intends to make these reports available in the main and regional offices of the Department of Health as well. N.Y. State Dep't of Health News Release (Jan. 22, 1975). This additional step is unlikely to greatly increase public knowledge of deficiencies, and further disclosure is needed.

168. 42 U.S.C. §§ 1395, 1396 (Supp. II, 1972).

169. Before 1972, there was some question whether survey reports by state agencies, directed to HEW, were specifically exempt from public disclosure requirements. 42 U.S.C. § 1306(a) (1970) gave the Secretary of HEW broad discretion in the disclosure area. Enacted in 1939, section 1306(a) was designed to prevent personal data about social security applicants from being disclosed, but was relied on by the SSA to refuse disclosure of nursing home inspection reports. This practice was challenged after enactment of the Freedom of Information Act, 5 U.S.C. § 552 (1970), which was designed to permit full disclosure of government information, subject only to narrow and well-defined exceptions. In Stretch v. Weinberger, 495 F.2d 639 (3d Cir. 1974), the court required disclosure, finding that the Freedom of Information Act, rather than section 1306(a), was controlling. It held that the purpose of the older rule, to prevent exploitation and humiliation of social security applicants, did not override the broad purpose of the Freedom of Information Act, to allow full disclosure of government information. A second case, Schechter v. Weinberger, 506 F.2d 1275 (D.C. Cir. 1974), relied on the *Stretch* rationale to reach the same holding of nonexemption from disclosure. The *Schechter* court amplified the Freedom of Information Act's impact on the SSA by noting that although the act protects from disclosure matters that are specifically ex-

lic is entitled to view inspection reports at the offices of the Social Security Administration and the local welfare department, but few are aware of this right and its effectiveness is questionable. Disclosure of cost data submitted to HEW by nursing homes and other providers also should be available to the public upon request.[170]

Inspections should occur more often—at night and during weekends when staff shortages are the worst, not just during weekdays—and should not be announced in advance. The desire to have records and key nursing home staff present is the reason for giving advance notice of inspections and for holding them during weekdays. Many violations go undiscovered when inspections are conducted only in this way, however.

Because persuasive policy reasons underlie the desirability of unannounced inspections, several states now utilize such procedures.[171] New York, relying on existing statutory authority, has announced it will no longer give advance notice.[172] California, Michigan, and Rhode Is-

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empted by statute, *see* 5 U.S.C. § 552(b)(3) (1970), section 1306(a) could not be construed as a specific statutory exemption because it vested complete, uncharted discretion in the Secretary. The same result was reached in Serchuk v. Weinberger, 493 F.2d 663 (5th Cir. 1974) (mem.).

In California v. Weinberger, 505 F.2d 767 (9th Cir. 1974), another suit to compel HEW to disclose survey reports, the court reached a contrary conclusion, holding that the Freedom of Information Act did not require disclosure. The court found section 1306(a) to be within the nondisclosure provision of 5 U.S.C. § 552(b)(3) (1970).

170. Two cases questioned HEW's public disclosure of cost data or financial information. In McCoy v. Weinberger, 386 F. Supp. 504 (W.D. Ky. 1974) (mem.), HEW was enjoined from releasing provider cost reports to the public on the ground that such disclosure would violate both HEW regulations and the Freedom of Information Act's "trade secret and financial information" exception. *See* 5 U.S.C. § 552 (1970). In American Hosp. Ass'n v. Weinberger, [1974 Transfer Binder] CCH MEDICARE-MEDICAID GUIDE ¶ 27,046 (D.D.C. 1974), a suit challenging the legality of HEW's decision to disclose cost reports to the public was dismissed after the American Hospital Association and HEW agreed that the Secretary would provide 10 days advance notice of any request of cost reports and would not disclose such reports until 10 days after the notice had been mailed.

The controversy over disclosure of financial data stemmed from HEW's failure to issue new regulations authorizing such disclosure. The decision to disclose, described as a policy shift, was announced in Part A, Intermediary Letter No. 74-18 (May, 1974), *found in* [1974 Transfer Binder] CCH MEDICARE-MEDICAID GUIDE ¶ 26,994. Technically, however, the Social Security Act, 42 U.S.C. § 1306 (1970), requires that no disclosure of information be made except as prescribed by regulation. The regulations provide for disclosure of information from financial reports only to certain federal and state employees. *See* 20 C.F.R. §§ 401.1-.6 (1974). On April 23, 1975, HEW announced proposed regulations which would accomplish the objectives of the policy shift and eliminate the problem which gave rise to the suits. The proposed regulations provide that the only SSA information which is exempt from disclosure is that relating to individuals. In all other cases, the SSA would release information pursuant to the Freedom of Information Act. *See* 40 Fed. Reg. 17849 (1975).

171. Reversing a "policy that has been heavily criticized since the inception of Medicaid in 1967," the Department of HEW now encourages states to conduct inspections of facilities without advance notice. N.Y. Times, Feb. 28, 1975, § 1, at 1, col. 4.

172. N.Y. State Dep't of Health News Release (Jan. 22, 1975). This policy shift was codified recently by S. 6543 (1975), *amending* N.Y. PUB. HEALTH LAW § 2801 (McKinney 1971 & Supp. 1974-75); *id.* § 2803 (McKinney Supp. 1974-75), which requires that each facility be inspected twice a year and that one of these inspections be unannounced.

land have enacted statutes expressly directing that inspections be unannounced and making it a misdemeanor for an inspector to notify a facility in advance.[173]

A reason offered for the reluctance to conduct unannounced inspections is that such inspections may violate the fourth amendment protection against unreasonable search and seizure.[174] In the principal cases in this area, *Camara v. Municipal Court*[175] and *See v. City of Seattle*,[176] the United States Supreme Court held that warrantless inspections by housing and fire officials violated the fourth amendment rights of the owners of the property involved. Despite *Camara* and *See*, unannounced inspections of nursing homes probably would be upheld. An important feature of both cases was that the area into which entry was sought was private. Further, these cases involved warrantless searches rather than searches without notice.

Moreover, nursing home inspections may fall within the exceptions set forth in *Camara* and *See*. In *See*, the Court noted that its decision did not prohibit warrantless searches of businesses inspected to determine whether a license should issue.[177] This exception encompasses a large number of nursing home inspections which are conducted for this purpose. Additionally, most such inspections do not involve entry into private areas. Thus, in *People v. White*,[178] a state case decided subsequent to *Camara* and *See*, a warrantless search of a California nursing home was upheld. The court held that a warrant was not required because a nursing home is open to the public.[179]

173. CAL. HEALTH & SAFETY CODE § 1421 (West 1973); MICH. COMP. LAWS ANN. § 331.653(e)(2) (1974); R.I. GEN. LAWS ANN. § 23-17.1-13 (Supp. 1974).

174. U.S. CONST. amend. IV.

175. 387 U.S. 523 (1967). Although the Court in *Camara* held that a warrant was required for housing code inspections, it indicated that traditional probable cause was not necessary for issuance of this sort of warrant. Rather, it was sufficient if reasonable administrative standards for conducting an area inspection are satisfied, considering factors such as the nature of the building or passage of time. *Id.* at 538.

176. 387 U.S. 541 (1967). Fire inspectors desired to inspect a commercial warehouse as part of a citywide effort to ensure compliance with the fire code. The Court specifically indicated that the warrant requirement was relevant only as to inspection of those portions of premises not open to the public. *Id.* at 545. *See also id.* at 545 n.6.

177. *Id.* at 546.

178. 259 Cal. App. 2d 936, 65 Cal. Rptr. 923 (Ct. App. 1968). The court, distinguishing between searches pursuant to licensing statutes which require inspections and inspections to enforce codes applicable to all buildings, held that *Camara* and *See* were not controlling. *Id.* at 940, 65 Cal. Rptr. at 927.

179. *Id.* at 942, 65 Cal. Rptr. at 927. *See* United States v. Biswell, 406 U.S. 311 (1972), wherein the Court upheld the constitutionality of a portion of the Gun Control Act of 1968, 18 U.S.C. §§ 921-928 (1970), which authorized warrantless inspections of a firearms dealer's records. The Court noted:

> if inspection is to be effective and serve as a credible deterrent, unannounced, even frequent, inspections are essential. In this context, the prerequisite of a warrant could easily frustrate inspection; and if the necessary flexibility as to time, scope, and frequency is to be preserved, the protection afforded by a warrant would be negligible.

406 U.S. at 316. Such an inspection is reasonable within the meaning of the fourth

2. *Certification.* A facility is not eligible for reimbursement under either Medicare or Medicaid unless it has a valid provider agreement. To obtain such an agreement, the facility must be in compliance with the relevant conditions of participation.[180] Provider agreements for SNF's may not exceed 12 full calendar months;[181] thus, annual review is required. Upon the completion of a survey, the state agency makes certification recommendations.[182] Where certification is sought both for Medicare and Medicaid, these recommendations are made to HEW's Division of Long Term Care Standards Enforcement, which makes the certification decision.[183] Whenever the Secretary certifies an institution to be qualified as an SNF for purposes of Medicare, the institution is deemed to have met the standards for certification under Medicaid.[184] In Medicaid only cases, the certification decision of the state survey agency is final, with the exception of LSC determinations which are the responsibility of HEW's Division of Long Term Care Standards Enforcement.[185]

The certification recommendations of the state survey agency will indicate that an SNF is one of the following: in full compliance with all conditions of participation; in compliance, but with deficiencies; or not in compliance. A facility found to be in full compliance is eligible for unconditional certification for a full 12-month provider agreement.[186] If a facility is not in compliance with one or more standards, it may be granted a reasonable time in which to achieve compliance.[187]

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amendment because when a "dealer chooses to engage in this pervasively regulated business and to accept a federal license, he does so with the knowledge that his business records . . . will be subject to effective inspection." *Id.* For a discussion of warrantless inspections, see F. GRAD, PUBLIC HEALTH LAW MANUAL 76-105 (1970).

180. 20 C.F.R. § 405.1906 (1974). A facility may be deficient with respect to an element, a standard, or a condition. Elements are examined to determine whether standards have been met; the examination of several standards determines whether the condition has been met. For example, one standard of the condition of adequate nursing services is 24-hour nursing care; one element of 24-hour nursing care is the availability of two nurses. Interview with Dr. Frank Furth, *supra* note 160.

181. 42 U.S.C. § 1395cc(a)(1) (1970), *as amended*, (Supp. II, 1972); 20 C.F.R. § 405.1904(a) (1974). The Secretary can grant a 2-month extension of a provider agreement where the health and safety of patients will not be jeopardized, if the extension is necessary to prevent irreparable harm to a facility or hardship to residents of a facility, or if it would be impracticable to determine, within the 12-month term, whether a facility was in compliance with the requisite standards. These findings should be made in writing and based on supportive evidence. MANUAL, *supra* note 158, § 6020.

182. 20 C.F.R. § 405.1902(a) (1974).

183. MANUAL, *supra* note 158, § 2000C. 20 C.F.R. § 405.1902(c) (1974), clearly provides that the certifications of the state agency only represent recommendations to the Secretary.

184. 42 U.S.C. § 1396i(a) (Supp. II, 1972).

185. MANUAL, *supra* note 158, § 2000E.

186. 20 C.F.R. § 405.1904(a) (1974). This certification does not preclude the state agency from inspecting the facility at any point during the period of its agreement.

187. *Id.* § 405.1907(b). Normally a provider would be expected to take the steps necessary to achieve compliance within 60 days. If it is unreasonable to expect compliance within this period, the Secretary may grant additional time, depending on the nature of the deficiency and its effect on patient care.

A deficient facility may be certified by the state agency if such deficiencies do not affect adversely the health and safety of patients.[188] Where the survey agency desires to do this, it must provide a statement of the deficiencies found, a description of corrective action, a time-phased plan of correction, and a scheduled time for resurvey within 90 days.[189]

If a facility is not in full compliance with all requirements, the period of certification must be limited to not more than 60 days after the end of the time specified in a written plan of correction approved by the Secretary,[190] or it may be certified for a full 12-month period, subject to automatic cancellation if the deficiencies are not corrected within 60 days of the time specified for correction.[191] A facility with deficiencies which substantially limit its capacity to render adequate care or which adversely affect the health and safety of patients is not eligible for certification.[192]

The certification procedures for ICF's parallel those for SNF's.[193] Because ICF's are only eligible for reimbursement under Medicaid, however, the certification recommendations of the state survey agency are made to the designated single state agency.[194] The term of an ICF provider agreement is not to exceed 1 year,[195] although certification may not be subject to a similar time limitation.[196] A certified facility may be in full compliance or in only partial compliance if it has deficiencies which neither jeopardize patient health or safety nor seriously limit the provider's capacity to render adequate care and if the facility provides the survey agency with an acceptable written plan of correc-

188. *Id.* § 405.1903(b).

189. *Id.* In deciding whether the deficiencies can be corrected, the state agency should consider whether a facility is willing to perform this task and whether it has the funds available to do it. MANUAL, *supra* note 158, § 2000C(4).

190. 20 C.F.R. § 405.1908(a)(1) (1974).

191. *Id.* § 405.1908(a)(2).

192. *Id.* § 405.1905(a). In this situation, the state agency must document its conclusion by describing the deficiencies, reporting the consultative efforts undertaken to assist the provider to comply and the provider's response to such efforts, and giving its assessment of the prospects for making the improvements necessary to achieve compliance. *Id.* § 405.1903(a).

193. *See generally* 45 C.F.R. § 249.33 (1974).

194. *See* text & note 185 *supra.*

195. 45 C.F.R. § 249.33(a)(6) (1974). An extension of up to 2 months is possible where the survey agency has given the single state agency written notice that: the health and safety of the patients will not be jeopardized; such extension is necessary to prevent irreparable harm to the facility or hardship on the patients; or that it is impracticable to determine, within the term of the agreement, whether a facility is complying with the requirements.

196. The single state agency must obtain certification from the state survey agency that an ICF is in compliance with applicable requirements. An ICF may be certified for up to 2 years even if there are fire safety or environmental deficiencies, provided that the institution submits an acceptable written plan of correction indicating: the steps to be taken to achieve compliance, a timetable of less than 2 years for these steps, and a finding by the state survey agency that the facility has the potential to complete these steps within the allowable 2-year period. *Id.* § 249.33(a)(2).

tion.[197] If a facility is certified with deficiencies, restrictions as to the certification period are imposed.[198]

One of the conditions with which an SNF must comply is the LSC.[199] An SNF's compliance with the LSC is a prerequisite to eligibility under either Medicare or Medicaid.[200] If recommended by the state survey agency, the Secretary may waive, for an appropriate period, those specific provisions of the Code which "if rigidly applied, would result in unreasonable hardship upon a skilled nursing facility, but only if such waiver will not adversely affect the health and safety of the patients."[201] Where a Medicaid only SNF is involved, the recommendations of the state survey agency ordinarily go only to the state agency that has authority to enter into a provider agreement. Nevertheless, certification recommendations relating to LSC compliance must go to the Secretary. Until the Secretary has considered the recommendations of the state survey agency, and unless he waives any LSC violations, the state agency may not enter into a provider agreement.[202]

ICF's are also required to comply with LSC requirements.[203] Before the single supervising state agency can execute an agreement with a facility, it must obtain certification from the state survey agency that the facility is in compliance with all requirements, including those of the LSC.[204] As with SNF's, the state survey agency is authorized to waive any provisions of the LSC, in accordance with criteria issued by the Secretary, if rigid application would result in unreasonable hardship to a facility. A waiver can be given only if it will not adversely affect the health and safety of the residents.[205]

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197. *Id.* § 249.33(a)(4).

198. *Id.* § 249.33(a)(4)(iii). The restrictions are the same as those indicated in the text accompanying notes 194-95 *supra.*

199. *See* discussion note 132 *supra.*

200. 42 U.S.C. § 1395x(j)(13) (Supp. II, 1972) indicates that for purposes of Medicare, an SNF must meet the provisions of the LSC. *See also* 20 C.F.R. § 405.1134 (a) (1974). 42 U.S.C. § 1396a(a)(28) (1970), *as amended,* (Supp. II, 1972), provides that any SNF receiving reimbursement under Medicaid must satisfy all the conditions contained in *id.* § 1395x(j).

201. 20 C.F.R. § 405.1134(a) (1974).

202. *See* text accompanying note 185 *supra.*

203. 45 C.F.R. § 249.12(a)(5) (1974). Those provisions applicable to institutional occupancy are to be utilized if a facility contains over 15 beds. If the facility contains 15 beds or less, is primarily used for treating alcoholism or drug abuse, and all of the residents are certified by a physician as being ambulatory and capable of following directions or taking appropriate action for self-preservation under emergency conditions, the state survey agency may use the residential occupancy provisions of the lodging or rooming house section of the LSC. *Id.*

204. *Id.* § 259.33(a)(2).

205. *Id.* § 249.12(a)(5)(ii). To ensure national uniformity, however, HEW issued proposed regulations transferring the authority to waive LSC violations of ICF's from the states to the Secretary. 40 Fed. Reg. 6368 (1975).

In addition to compliance with federal regulations and the LSC, a facility must comply with state laws and regulations and be licensed under state law.[206] The same agency which conducts surveys for the purpose of ascertaining compliance with federal requirements, ascertains compliance with state standards. All states require nursing homes to be licensed and generally issue licenses for a specific period.[207] New York, which has a comprehensive health planning system, also requires an applicant for a nursing home license to demonstrate the need for the facility.[208]

The certification process involves broad discretion on the part of enforcement agencies. Full certification may be granted or certification withheld altogether, depending on whether there are deficiencies and whether an enforcement agency views them as severe.[209] Most litigation arising from certification has been brought by facilities.[210] Nursing home residents have not challenged certification decisions, although they have standing to do so.[211] Greater participation by residents or their representatives in the certification process may yield positive results, and nursing home residents should consider challenging decisions to certify where they believe there are deficiencies and where there has not been full compliance with procedural requirements in the certification process.[212]

B. *Public Sanctions for Noncompliance*

1. *Decertification and Termination of Provider Agreements.* Both the Secretary of HEW and state agencies are authorized to terminate a provider agreement with any facility that is not complying with applicable standards,[213] or they may refuse to renew an agreement with

206. 42 U.S.C. § 1395x(j)(9) (1970); 20 C.F.R. § 405.1120 (1974) (SNF's). ICF's are covered by 42 U.S.C. § 1396d(c) (1970), *as amended*, (Supp. III, 1973); and 45 C.F.R. § 249.12(a)(1)(vii) (1974). State standards must be met even where they are more strict than any applicable federal requirements.

207. *See, e.g.*, ARIZ. REV. STAT. ANN. §§ 36-421 to -432 (1974); COLO. REV. STAT. ANN. §§ 12-13-101 to -107 (1974); KY. REV. STAT. ANN. §§ 216.610-.690 (1971).

208. N.Y. PUB. HEALTH LAW §§ 2801a(3) (McKinney 1971); *id.* § 2802(2) (McKinney Supp. 1974).

209. This discretion is limited, however. *See* 45 C.F.R. § 405.1908 (1974).

210. *See* text & notes 216-37 *infra*.

211. Whether residents do have standing to challenge an HEW certification decision depends upon whether the decision causes them injury in fact and whether the alleged injury is to an interest arguably within the zone of interests protected by the Social Security Act. *See* United States v. SCRAP, 412 U.S. 669 (1973); Sierra Club v. Morton, 405 U.S. 727 (1972); Barlow v. Collins, 397 U.S. 159 (1970); Association of Data Processors v. Camp, 397 U.S. 150 (1970).

212. Because of the increased need for certified facilities under Medicare and Medicaid, the SSA has certified substandard facilities as being in "substantial compliance" or granted them "conditional compliance" status and requested regional offices to reconsider homes that had earlier been deemed substandard. *See* C. TOWNSEND, *supra* note 6, at 42.

213. *See* 20 C.F.R. § 405.614 (1974); 45 C.F.R. § 249.33(a)(4) (1974). *See also*

a facility.[214] These actions have important consequences for nursing homes because of their economic dependence on Medicaid and Medicare. Indeed, most homes cannot survive if these funds are withdrawn, a fact which illustrates the strength of these sanctions. Thus, the fear of losing its economic life blood may induce a facility into compliance.

In some cases, however, a facility will refuse to comply, even in the face of a threat to withdraw all federal financial assistance. This may occur, for example, when the deficiencies can be cured only by expensive alterations, which the home claims are beyond its means. In such cases, decertification and termination sanctions are largely ineffective. This is due, in part, to the consequences that closing a facility has upon the patients who must be relocated. Because relocation has been shown to have a detrimental effect on the health of elderly nursing home patients,[215] agencies are reluctant to take action necessitating a transfer. Because of the difficulty of finding adequate alternative care facilities, this reluctance is compounded in areas where beds are in short supply. Bureaucratic paralysis often results. Reluctant to close a home because adequate alternatives are unavailable, the agency sanctions serious deficiencies for extended periods.

The effectiveness of termination or nonrenewal has been undercut even further by several recent cases requiring that a hearing be held before such action is taken. *Maxwell v. Wyman*,[216] a suit brought by the Maxwell Nursing Home, a small facility located in New York, is typical of these actions. The New York Department of Social Services decided not to renew its Medicaid provider agreement with the Maxwell home for 1972[217] because of LSC violations.[218] Maxwell re-

42 U.S.C. § 1395y(d) (Supp. II, 1972). Section 1395y(d) prohibits the Secretary from making Medicare payments where he determines that a provider has knowingly and willfully made false statements in application for benefits, submitted bills substantially in excess of customary charges, or furnished services which were of grossly inferior quality or were substantially in excess of an individual's needs. 20 C.F.R. § 405.614 (1974) specifically authorizes the Secretary to terminate a provider agreement prior to its normal expiration where the conditions of participation are no longer met. Only 15-days notice need be provided before the effective date of the termination. Providers are not entitled to a hearing until after the termination determination.

An SNF's provider agreement will not be valid evidence of its compliance with the requisite conditions of participation if, through onsite validation surveys or other means the Secretary determines that the state survey agency was not sufficiently thorough or that some conditions were not met. Without a valid provider agreement, the SNF would no longer be entitled to reimbursement. 45 C.F.R. § 249.10(b)(4)(i) (1974). An ICF provider agreement may be terminated on the basis of these same determinations. *Id.* 249.10(b)(15)(ii) (1974).

214. 20 C.F.R. § 405.1908(b) (1974); 45 C.F.R. § 249.33(a)(2) (1974).

215. *See* INTRODUCTORY REP., *supra* note 3, at 17-18; Farrar, Ryder & Blenkner, *Social Work Responsibility in Nursing Home Care*, 45 SOC. CASEWORK 527 (1964).

216. Maxwell v. Wymann, 458 F.2d 1146 (2d Cir. 1972). This suit was a class action involving 148 SNF's in New York state.

217. As a result of surveys made prior to January 1971, the Department of Social Services refused to enter into 12-month agreements with the facilities involved, but en-

quested a hearing prior to the termination of Medicaid reimbursement, but federal regulations did not require such a hearing and none was offered. Joined by the owners of other noncomplying facilities facing termination, the proprietor of the home sued the Department of Social Services and HEW, seeking an injunction prohibiting termination without a prior hearing. Relief was denied by the district court, but the United States Court of Appeals for the Second Circuit reversed, ordering the state to hold an evidentiary hearing for each facility to determine whether a waiver should be granted.[219] The court of appeals' decision was not based upon constitutional grounds, however.[220] Instead, the court relied upon its interpretation of New York's licensing statute, which requires that a hearing be held where a license is to be "limited."[221] The court concluded that the state's proposed action had the effect of limiting the operating licenses of the affected homes.[222]

While the owners' appeals from the court-ordered evidentiary hearings were pending,[223] HEW announced its intention to terminate federal reimbursement to New York for Medicaid care provided by these homes. New York sought an injunction against this termination, and the Second Circuit held that HEW could not terminate reimbursement until judicial review of New York's administrative process had been completed.[224] The owners' appeals from the Department of Social Services' decision not to grant waivers resulted in numerous reversals.[225] As a consequence, many of the homes continue to operate and to receive reimbursement from Medicaid.

In another recent case, the right of a nursing home to a hearing before a decision not to renew a provider agreement was based on con-

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tered into 6-month agreements because of community need. The 6-month agreements were renewed for a similar period ending December 31, 1971. *Id.* at 1149 n.2.

218. *Id.* at 1150.

219. *Id.* at 1152.

220. *Id.* at 1151 n.7.

221. N.Y. PUB. HEALTH LAW § 2806(2) (McKinney 1971).

222. 458 F.2d at 1151.

223. Of the 148 homes initially involved and offered hearings, 110 hearings were held. Waivers were granted to 22 facilities and approximately 40 homes appealed from adverse decisions. Maxwell v. Wyman, 478 F.2d 1326, 1327 n. 2 (2d Cir. 1973).

224. *Id.* at 1329.

225. In Maxwell v. Lavine, 41 App. Div. 2d 346, 343 N.Y.S.2d 231 (App. Div. 1973), experts for the nursing homes testified that other safety devices were being used so that the homes were not unsafe even though they failed to comply with the LSC. The court agreed. In Pollock v. Lavine, 41 App. Div. 2d 352, 343 N.Y.S.2d 237 (App. Div. 1973), in response to the state assertion that LSC violations were present, experts testified for the facilities that they would be safe if certain repairs were made. The court remanded to determine if such repairs were in fact completed; if so, the facilities would be eligible. In Trumbull v. Lavine, 41 App. Div. 2d 349, 343 N.Y.S.2d 235 (App. Div. 1973), the three facilities involved did not have expert testimony to rebut the position of the state that there were LSC violations nor did they assert that sufficient alternative safety precautions had been taken. Therefore, the court upheld the state's determination denying waiver.

stitutional grounds. In *Paramount Convalescent Center, Inc. v. Department of Health Care Services*,[226] a California appellate court affirmed a lower court's determination that an SNF is constitutionally entitled to an evidentiary hearing before the state can refuse to renew a Medicaid provider agreement. The dissent disagreed. Pointing out that a provider agreement is a contract, not a license, the dissenters noted that due process protections do not attach to the expectation of a contract renewal. Therefore, a prior hearing should not have been required for a state's decision not to renew a provider agreement.[227]

In contrast to *Maxwell* and *Paramount*, which involved refusals to renew provider agreements, *Shady Acres Nursing Home v. Canary*[228] involved termination of a provider agreement during the term of the agreement and a refusal to renew an expired agreement. The court distinguished the two situations, limiting the right to notice and a hearing to terminations that occur during the term of an agreement.[229] Noting that facilities have provider agreements which are subject to fixed termination dates, the court ruled that a facility has no property interest beyond this date, and a hearing is not required before a decision not to renew.[230]

A home's claim to a hearing is stronger where a provider agreement is to be terminated during the agreement's term than when the state will not renew an agreement. The distinction between actions taken during the term of a provider agreement and after the agreement has expired is based on *Board of Regents v. Roth*,[231] in which the Supreme Court held that a nontenured teacher who was hired for a fixed 1-year term was not entitled to a hearing prior to a decision not to renew his contract. The Court noted that the due process protections of the fourteenth amendment are applicable only where an individual's liberty or property interest was at stake: "To have a property interest in a benefit, a person clearly must have more than an abstract need or desire for it. He must have more than a unilateral expectation of it. He must, instead, have a legitimate claim of entitlement to it."[232] The Court held that because Roth's expectation that his contract might be renewed was not such an interest, he was not entitled to a hearing.

226. 43 Cal. App. 3d 35, 117 Cal. Rptr. 321 (Ct. App. 1974).
227. *Id.* at —, 117 Cal. Rptr. at 325-26.
228. 39 Ohio App. 2d 47 (1973).
229. *Id.* at 56-57.
230. Any contract, which specifically provides a term to run, with a fixed termination date, voluntarily entered into by the parties, cannot be said to create a property right in any party thereto that will result in its renewal or extension, and such a refusal does not constitute a denial of due process of law.
Id. at 64.
231. 408 U.S. 564 (1972).
232. *Id.* at 577.

In *Ross v. Wisconsin Board of Health and Services*,[233] a nursing home's right to a prior hearing was considered in the context of another form of adverse government action. The issue in *Ross* was the constitutionality of a Wisconsin statute that authorized the state immediately to withdraw patients from a home when an emergency which resulted from noncompliance with department standards placed patients' health, safety, or welfare in jeopardy. Utilizing the *Roth* test, the court determined that "[n]ursing home operators do have more than an abstract need or desire to retain patients for whom public support is received, as well as more than a unilateral expectation of so doing."[234] Therefore, the court concluded that ordinarily a hearing must be allowed prior to the withdrawal of patients. The court added, however, that in a true emergency the governmental interest in protecting the residents would justify removing patients without a prior hearing, if a hearing were held within a reasonable time thereafter.

One judge, concurring in *Ross*, applied a different analysis.[235] In his opinion, a nursing home was an ordinary vendor with no property interest in continued business with the government; therefore, the home had no right to a hearing because of proposed government action affecting this interest. Rather, the home's right to a hearing stemmed from the effect of the proposed action upon its reputation.[236]

Finally, in a case involving the right of a Medicare fiscal intermediary to suspend payments to an SNF without a prior hearing, one district court held that the failure to provide an evidentiary hearing prior to deducting amounts allegedly overpaid was a denial of due process.[237]

Thus, the authority of HEW or a state agency to summarily terminate or refuse to renew a provider agreement is uncertain. While the cases granting a prior hearing seem to reflect judicial concern for the consequences of the proposed action on the patients of the affected facility, the effect has been to allow patients to remain in seriously deficient homes undercutting enforcement activities aimed at remedying these deficiencies. Further, the cases ignore the well established authority of administrative agencies to act summarily to protect public

233. 369 F. Supp. 570 (E.D. Wis. 1973).
234. *Id.* at 572.
235. *Id.* at 573-75 (Reynolds, J., concurring).
236. *Id.* at 573-74, *citing* Wisconsin v. Constantineau, 400 U.S. 433 (1971), where the Court ruled that a statute which authorized posting a notice in retail liquor outlets not to sell to a particular individual who has a "drinking problem" was unconstitutional. Where a person's reputation or integrity is at stake, due process requires notice and an opportunity to be heard.
237. Coral Gables Convalescent Home v. Richardson, 340 F. Supp. 646 (S.D. Fla. 1972).

health and safety[238] as well as several recent cases limiting the range of property interests that are entitled to the protection of prior hearing.[239]

The requirement that a hearing be held substantially increases the cost and consequently reduces the effectiveness of government decertification and termination actions. To satisfy this requirement, it is necessary to have a hearing examiner, an attorney to represent the agency, and the agency inspection team available to testify at the hearing. Further, an appeal from an adverse hearing decision is probable, further delaying the proposed action.[240] This is a time consuming process at best. Because many agencies lack sufficient attorneys, hearing examiners, and other resources and because the homes may be expected to use any available delaying tactics, the process proceeds at a snail's pace.

When termination sanctions are used, it is important that nursing home residents and their families be able to participate in the hearing. *Shady Acres* held that residents are entitled to notice and hearing before a provider agreement is terminated, and in analogous settings, the rights of welfare recipients to participate in state compliance hearings[241] and of tenants to participate in decisions affecting their tenancy have been upheld.[242] Nursing home residents should be able to request that an agreement be terminated or not renewed and should have standing to participate in administrative hearings or litigation resulting from these actions.

2. *License Suspension or Revocation.* All nursing homes are required to be licensed by the state in which they are located, and these licenses generally are subject to periodic review.[243] Where a home fails to comply with standards of quality or other conditions, the state agency may initiate proceedings to suspend or revoke the license. In some states, no adverse action may be taken without a prior hearing. Others authorize temporary suspension without a hearing where pub-

238. *See* Goldberg v. Kelly, 397 U.S. 254, 263 n.10 (1970); 1 K. DAVIS, ADMINISTRATIVE LAW TREATISE §§ 7.08, 7.18-.19 (1958, Supp. 1970); F. GRAD, *supra* note 179, at 108-18.

239. *See* Arnett v. Kennedy, 416 U.S. 134 (1974); Board of Regents v. Roth, 408 U.S. 564 (1972).

240. *See generally* text & notes 223, 225 *supra.*

241. *See* National Welfare Rights Organization v. Finch, 429 F.2d 725 (D.C. Cir. 1970).

242. *See* Marshall v. Lynn, 497 F.2d 643 (D.C. Cir. 1973); Thompson v. Washington, 497 F.2d 626 (D.C. Cir. 1973). *Thompson* and *Marshall* required that tenants be notified of proposed rent increases and that they be given the opportunity to comment, in writing, on the increases. Neither case required that a hearing be held before an increase was approved. In addition, HUD has recently proposed regulations granting tenants the right to notice of proposed increases and the opportunity to submit written comments. *See* 39 Fed. Reg. 32736 (1974). *See also* Gellhorn, *Public Participation in Administrative Proceedings*, 81 YALE L.J. 359 (1972).

243. *See* F. GRAD, *supra* note 179, at 54-74.

lic health or safety is threatened.[244] Of course, judicial review is available from an administrative decision revoking a license.[245]

License suspension and revocation have the same advantages and disadvantages as provider agreement termination. The threat of license revocation may induce a facility to comply. Where the facility does not respond, however, license revocation is a slow and unwieldy sanction, requiring the substantial investment of agency resources and involving considerable delay. Further, a facility's entitlement to a hearing prior to license revocation is increasingly clear, even where not authorized by statute.[246]

3. *Reimbursement Control.* Reimbursement can be a useful technique to improve the quality of care. Rates can be decreased where deficiencies exist and can be increased when a home provides excellent care. To be effective, reimbursement rate differentials must be sufficiently great to induce a home to make the desired changes, for if the cost of compliance exceeds the reimbursement increases or decreases, the system will be ineffective. Additionally, the system must be capable of more frequent and timely rate adjustment than now occurs. Where there is a decision to penalize the home by reducing reimbursement, appeal of the decision to reduce reimbursement will cause delay and reduce the effectiveness of the remedy. For this reason, positive incentives, increasing reimbursement for improved care, may be more effective.[247]

4. *Appointment of a Receiver.* As an alternative sanction, enforcement agencies might consider initiating actions seeking the appointment of a receiver for a noncomplying facility.[248] The appoint-

244. *See* N.Y. PUB. HEALTH LAW § 2806 (McKinney 1971).

245. *See* 4 K. DAVIS, *supra* note 238, §§ 28.01-.21.

246. *See* 1 K. DAVIS, *supra* note 238, §§ 7.18-.19; F. GRAD, *supra* note 179, at 54-74.

247. New York has adopted an approach which provides increased flexibility in reimbursements to proprietary nursing homes by allowing additional compensation if the facility's costs are lower than the average costs of similar facilities and if it has no significant deficiencies. This additional amount is referred to as an incentive allowance. *See* 10 N.Y.C.R.R. § 86.31 (1975). Similarly, a New York court has held that the Commissioner of Health may refuse to reimburse homes with significant deficiencies at a rate higher than the weighted average for homes without such deficiencies. Concourse Nursing Home v. Ingraham, 169 N.Y.L.J. No. 89, 18 (Sup. Ct., Special Term N.Y. Co. 1973).

Connecticut uses a reimbursement scheme which adds a twist to the basic flat fee procedure. As in other states, payments to a facility differ depending on whether it is classified as a SNF or ICF. In addition, payments to homes within either category are graduated in accordance with a point system. Facilities are awarded points on the basis of their performance in certain categories and are given demerits for certain failures. It is alleged that the quality of care provided has been greatly improved through this classification scheme. SUPPORTING PAPER No. 1, *supra* note 51, at 229-33, *citing* Foote, *Progress in Nursing Home Care*, 202 J.A.M.A. 296 (1967).

248. *See* 4 HEALTH LAW PROJECT, U. PA. LAW SCHOOL, *supra* note 121, at 124; Grad, *Upgrading Health Facilities: Medical Receiverships as an Alternative to License Revocation*, 42 U. COLO. L. REV. 419 (1971).

ment of a receiver is a provisional remedy which is controlled by equitable principles[249] and allowable in conjunction with an action which requests other final relief, such as a declaratory judgment or damages.[250] Receiverships have been authorized by statute in a number of jurisdictions, including special provisions for receivers to rectify problems in specific areas, such as housing.[251] Additionally, a receiver may be appointed even where no statute specifically authorizes such an appointment.[252]

In the housing context, receivership statutes generally authorize either an enforcement agency or the tenants of a dilapidated building to file a civil action seeking appointment of a receiver to assume control of a building whose owners have failed to correct serious deficiencies.[253] The receiver is authorized to utilize rental revenues to make repairs and, in some states, to borrow funds necessary to complete repairs, using the building as collateral. Other statutes authorize imposition of liens to secure repayment by the owners.[254] The function of a receiver in the health area would be similar to his role in housing. He would operate or supervise the operation of a noncomplying nursing home and use revenues to bring the home into compliance with existing standards. If necessary, the receiver could authorize structural repairs needed to achieve compliance.

The advantage of this remedy is that it directly achieves the rehabilitation that license revocation and similar remedies try to induce in-

249. Although this remedy is typically utilized to protect a property interest, it has considerable flexibility. In one case, Turner v. Goolsby, 255 F. Supp. 724 (S.D. Ga. 1965), the court appointed the state superintendent of schools as receiver of a local district to prevent illegal use of school funds, develop an appropriate bussing plan, and integrate the school system.

250. Goldfine v. United States, 300 F.2d 260 (1st Cir. 1962); SEC v. Republic Nat'l Ins. Co., 378 F. Supp. 430 (S.D.N.Y. 1974).

251. *See, e.g.*, CONN. GEN. STAT. ANN. § 19-347b (Supp. 1975); MASS. ANN. LAWS ch. 111, § 127H (1975); N.J. STAT. ANN. §§ 40:48-2.12(h) to -2.12(*l*) (1967); N.Y. MULT. DWELL. LAW § 309(5) (McKinney 1974). Statutory authorization is advantageous because a court may be more willing to impose a receivership under statutory authority. Additionally, a statutory scheme can be established that will shape the remedy more effectively.

252. Inland Empire Ins. Co. v. Freed, 239 F.2d 289 (10th Cir. 1956); McDonald v. McDonald, 351 Mich. 568, 88 N.W.2d 398 (1958); Grayson v. Grayson, 222 Ore. 241, 352 P.2d 738 (1960).

253. *See* N.Y. REAL PROP. ACTIONS LAW §§ 769-782 (McKinney Supp. 1974). The constitutionality of the New York receivership provision was upheld in *In re* Dep't of Bldgs., 14 N.Y.2d 291, 200 N.E.2d 432, 251 N.Y.S.2d 411 (1964).

254. The procedure is basically as follows: a government agency certifies the existence of a nuisance which constitutes a serious threat to life, health, or safety. If a 21-day order to remove the nuisance is not complied with, the department can apply to a court for appointment of a receiver and for a lien in favor of the state to secure repayment of costs incurred by the receiver in removing or remedying the condition. If income from the property is inadequate to cover the cost of removing the nuisance, government funds are advanced to the receiver in return for a lien. A revolving fund is set up for this purpose, and the receiver is to repay the amounts from the proceeds of any amounts he recovered. N.Y. MULT. DWELL. LAW § 309(5) (McKinney 1974).

directly.[255] In addition, relief can be obtained more quickly since courts usually act promptly in these cases and owner appeals are unlikely to stay or postpone the receiver's appointment.[256] Enforcement agencies should give serious consideration to utilizing receiverships. Where necessary, statutes modeled on the housing receivership statutes should be enacted to authorize receiverships in the nursing home context.[257] Drafters of such statutes should not confer the exclusive right to initiate receivership actions on the enforcement agencies, however. Residents and their families or guardians should be given specific authority to file such actions.

5. *Injunctions.* Generally, state enforcement agencies are empowered to seek injunctions against violations of laws and regulations that the agency is charged with enforcing.[258] This can be an effective sanction because an injunction can be obtained quickly and the violator is placed under the supervision of a court that is empowered to penalize any violations of the injunction. An injunction is particularly well suited to correct hazardous conditions or violations of patients' rights, such as the retaliatory transfer of a patient. This remedy appears to be underutilized, however, for reasons which are unclear. Staff shortages, bureaucratic custom, and lack of cooperation by the state attorney general's office probably are involved. In addition, courts sometimes are reluctant to issue preliminary injunctive relief in actions intended to culminate in a permanent injunction.[259] None of these problems is insurmountable, however. Enforcement agencies should make more use of injunctions to improve nursing home conditions.

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255. It is possible that conditions in facilities that are not involved in the proceedings might improve as well. This conclusion follows from experiences under the New York housing receivership law.

> As of early 1966, some 120 buildings have been placed in receivership. . . . The law has been effective, however, not only rehabilitating buildings in which the proceedings culminated in the appointment of a receiver, and in buildings in which receivership proceedings were actually begun, though not consummated; the threat of receivership has also resulted in substantial improvements in buildings not directly affected.

Gribetz & Grad, *Housing Code Enforcement: Sanctions and Remedies*, 66 COLUM. L. REV. 1254, 1273 (1966).

256. The individual seeking the receivership applies for a show cause order, or equivalent procedure, with a prompt return date. This takes precedence over most other court business. Studies in New York have indicated that the majority of these proceedings take less than 2 months from the time of filing to final disposition. Only 5 percent took more than 6 months. Note, *Article 7-A Revisited: New York City's Statutory Rent Strike Law*, 8 COLUM. J.L. & SOC. PROB. 523, 532 (1972).

257. N.Y. PUB. HEALTH LAW § 2862(4) (McKinney 1971) authorizes the appointment of a temporary or a permanent receiver for nonprofit nursing home companies to prevent or correct actions prejudicial to the interests of the residents or the public.

258. *See generally* F. GRAD, *supra* note 179, at 146-54. N.Y. PUB. HEALTH LAW § 2801-C (McKinney Supp. 1974) provides that the attorney general is to seek an injunction against the violation or threatened violation of any public health law or regulation upon the request of the public health council or commissioner.

259. *See* People v. Hatchamovitch, 40 App. Div. 2d 556, 334 N.Y.S.2d 565 (App. Div. 1972); People v. Dobbs Ferry Medical Pavillion, Inc., 69 Misc. 2d 886, 332 N.Y.S.2d 186 (Sup. Ct. 1972).

6. *Fines.* Although state enforcement agencies normally have the authority to impose fines for violations of health laws or regulations,[260] this economic sanction has not been used effectively. Often the fines are nominal in amount, and no real effort is made to collect the fines that have been assessed. Fines can be an effective sanction, however,[261] if they are assessed in substantial sums and collected promptly. The nursing home operator would then have a strong economic incentive to bring his facility into compliance. Effectiveness can be increased if fines are flexibile in amount. Violations affecting life and safety should be subject to large fines, while less serious violations should carry smaller penalties. Fines could be imposed for each day the violation continues unabated and could be increased for recurring violations. Where an administratively assessed fine has not been paid, a civil suit should be filed promptly and given precedence on the trial docket so that a judgment will be entered and execution obtained without delay.[262]

7. *Criminal Sanctions.* Both the federal[263] and state[264] enforcement agencies have the power, in appropriate situations, to seek criminal sanctions for misconduct by nursing home operators. But criminal penalties have not served as effective deterrents to violations of stand-

260. *See* N.Y. PUB. HEALTH LAW § 12 (McKinney Supp. 1974). The New York law imposes a fine of up to $1,000 for violations of any statute or regulation of the Public Health Law for which a civil penalty has not been expressly prescribed.

261. *See* F. GRAD, *supra* note 176, at 139-45.

262. California recently adopted such a system. Violations are categorized according to severity and fines vary accordingly. A strict timetable is established under which inspections are followed promptly by citations. The operator is given a short time in which to notify the department whether he intends to contest the citation and proposed fine. If he does not contest the citation, administrative action becomes final. If he contests, an informal conference is required to be held promptly. When the dispute is not settled at the conference, the operator may further contest the fine if he notifies the department within a brief period of time. The department then notifies the attorney general who is directed to initiate promptly a civil action to collect the fine. Such suits are accorded priority over virtually all other actions. *See* CAL. HEALTH & SAFETY CODE §§ 1417-1439 (West Supp. 1975).

263. The Social Security Amendments of 1972 imposed the following criminal sanctions: one who makes fraudulent statements in an application for benefits, converts benefits, or participates in kickback schemes or bribes, may be imprisoned for up to 1 year and fined up to $10,000. A fine of up to $2,000 and imprisonment of 6 months may be invoked against anyone who knowingly and willfully makes or induces a false statement or representation of a material fact with respect to the conditions of a facility in order that it might meet the qualifications of a given category, such as SNF or home health agency. These sanctions are applicable to facilities seeking reimbursement under Medicare, 42 U.S.C. § 1395nn (Supp. II, 1972), or under Medicaid. *Id.* § 1396h (Supp. II, 1972). Additionally, 42 U.S.C. § 1307(a) (1970) imposes a fine of up to $1,000 and imprisonment of up to 1 year for making a false representation concerning the requirements of Social Security with intent to defraud. Several sections of the United States Code that have general applicability to fraud, falsification of claims, and efforts to improperly obtain funds from the United States, provide penalties ranging up to $10,000 and/or imprisonment for 10 years. A nursing home operator could be subject to the penalties prescribed by these sections for any abuse of the Medicaid and Medicare programs for personal gain.

264. N.Y. PUB. HEALTH LAW § 2897-B (McKinney 1971) for example, makes it a misdemeanor to sell or fraudulently obtain an administrator's license or to act as an ad-

ards involving patient care or safety.[265] This is true for the same reasons that housing code enforcement agencies have found the criminal sanction to be ineffective in obtaining compliance.[266] Judges do not regard these violations as criminal in nature and are reluctant to impose jail sentences or large fines. Substantial trial delays are available and violations must be proven beyond a reasonable doubt. Moreover, criminal sanctions result only in retribution against the owner rather than rehabilitation of the facility. Thus, in the area of care and safety standards, the civil sanctions described earlier offer more promise of producing results and should be used in place of criminal sanctions.

Criminal sanctions can and should be used, however, when financial irregularities are involved. Doublebilling, padded payrolls, and conversion of assets to personal use are examples of common criminal practices in some segments of the nursing home industry. Some blatant violations, such as billing personal vacations to Medicaid, should be detected easily and convictions readily obtained. Other more subtle violations are more difficult to detect. Because of the difficulties of detection and proving criminal intent, convictions will not be as easily obtained. Greater efforts are needed to detect these violations and to deter their recurrence.[267]

III. PRIVATE ENFORCEMENT DEVICES

Enforcement should not be the exclusive domain of public agencies. Yet, because nursing home residents often are frail and vulnerable, it is appropriate for the principal burdens of enforcement to lie

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ministrator under fraudulent misrepresentation of material fact. This is punishable by imprisonment of up to 1 year and a fine of up to $5,000. N.Y. PENAL LAW § 210.45 (McKinney 1967) provides that the making of a false written statement on an instrument which declares that such statements are punishable is a class A misdemeanor which is punishable by up to 1 year imprisonment. Other statutes proscribe the falsification of business records. *Id.* §§ 175.00-.15. The offering of an instrument to a public official that is to become part of his official records is a class A misdemeanor if one knows that it contains false statements. *Id.* § 175.30. If such action is taken with the intent of defrauding the state, it is a class E felony, punishable by up to 4 years imprisonment. *Id* § 175.35.

265. Statutes that proscribe crimes such as assault and manslaughter should be available to protect nursing home patients. Because of special needs, it may also be useful to provide statutes which are specifically drafted to protect the elderly. South Carolina adopted such legislation in June, 1974. Modeled after child abuse statutes, the legislation is entitled, "An Act To Prohibit The Abuse, Neglect or Exploitation of A Senile or Developmentally Disabled Person; To Provide Protective Services For Such Person and To Provide Penalties." Violation of this act is a misdemeanor, punishable by a fine of up to $500 or imprisonment for up to 90 days. S.C. CODE ANN. §§ 71-300.71-.81 (Supp. 1974).

266. Gribetz & Grad, *supra* note 255, at 1275-81.

267. New York recently announced several initiatives to check abuses in the nursing home field. A special state commission has been established to study the nursing home industry and the state's enforcement mechanism, and to make legislative and administrative recommendations. In addition, a special state prosecutor has been created to investigate and prosecute abuses in nursing homes.

with these agencies. In even the best circumstances, however, the interests of the public and of agencies charged with protecting the public sometimes diverge.[268] Nursing home enforcement agencies are not model regulators and the pervasive problems in nursing homes point to the need for alternative enforcement devices.

An illustration of this point is the receivership proposal outlined earlier.[269] The authority to petition for the appointment of a receiver must not be left solely with government agencies. For a variety of reasons, unrelated to the merits of a particular case, the agency may choose not to utilize the device; thus, patients themselves must have this power so that they have standing to seek an appointment when they consider that conditions in the home are sufficiently serious to justify this step. Similarly, the power to seek declaratory and injunctive relief can be a powerful tool in the hands of patients and can augment the efforts of enforcement agencies.[270] Examples of situations in which such actions would be desirable are where patient transfers are proposed, where restraints are utilized inappropriately, and where hazardous conditions continue uncorrected.

A. *Private Involvement in Public Enforcement*

The failure of public enforcement agencies to compel compliance with safety and patient care standards is clear.[271] Why this is so is not so clear, however. Part of the problem is public neglect. The quality of life in nursing homes has only recently received public attention. As a result, enforcement agencies have been underfunded and understaffed. In addition, the remedies utilized by public agencies are unsatisfactory, and public enforcement is subject to political and other extra-legal pressures which limit effectiveness.

Greater private involvement in the public enforcement process can rectify these deficiencies. Simple scrutiny by the public is invaluable. Blatant abuses and regulatory favoritism toward the industry are less likely to occur when the enforcement agency's actions are watched by the public. Increased access to regulatory agencies is also required. Inspection results and cost data, already available on a limited basis, should be distributed more widely.[272] Where members of the public are rebuffed in efforts to obtain information from agencies, they should file suits under federal and state freedom of information laws to force disclosure.[273]

268. *See* J. SAX, DEFENDING THE ENVIRONMENT 52-62 (1971).
269. *See* text & notes 248-57 *supra.*
270. *See* text & notes 258-59 *supra.*
271. *See* discussion notes 10, 133 *supra.*
272. *See* text & notes 167-70 *supra.*
273. For a discussion of the federal Freedom of Information Act and its use in in-

The agencies themselves should invite greater public participation in the regulatory process to augment their staff capabilities. For example, agencies could establish consumer complaint centers, like those New York recently announced,[274] and promulgate regulations requiring nursing homes to allow lawyers, social workers, and others to visit homes at any time, as was done in Pennsylvania.[275] Where an agency is reluctant to take such steps, the public should try to effectuate these reforms by administrative rulemaking, litigation, or public pressure.

Formal recognition of private involvement in public regulation is needed. Enforcement agencies should be required to notify nursing home residents of proposed actions which may affect them, such as reimbursement rate changes, license revocation, or provider agreement terminations. Residents and other interested persons also should be able to participate in all proceedings affecting the home. The form of this participation would depend on the nature of the proposed action and the type of proceedings. Where no hearing is held, it may be sufficient to permit patients to submit written statements. This may be appropriate, for example, in determinations regarding reimbursement rates.[276] Where there is an evidentiary hearing, residents and other affected parties should have standing to participate, with the right to present evidence, examine and cross-examine witnesses, submit memoranda, make oral argument, and appeal from adverse decisions. Where the hearing is legislative in nature, residents and others should have the same right to participate as nursing home operators.[277] It may be necessary to make special arrangements to enable nursing home residents to participate in the administrative process. For example, hearings may have to be held in the nursing home and special notice procedures devised so that patients will have a realistic opportunity to participate.[278]

Residents also should consider suing enforcement agencies where homes are certified in spite of deficiencies, where the agencies fail to

spection suits, see note 169 *supra*. In Citizens for Better Care v. Reizen, 51 Mich. App. 454, 215 N.W.2d 576 (1974), the 1969 Michigan Administrative Procedures Act, MICH. STAT. ANN. §§ 3.560(103)-(206) (Supp. 1975), was held to require disclosure of data on nursing homes. The court's interpretation was guided by federal court decisions concerning the federal Freedom of Information Act.

274. *See* discussion note 165 *supra*.

275. *See* discussion note 121 *supra*.

276. *See* text & notes 23-29, 41, 247 *supra*.

277. For a discussion of the differences between a judicial hearing and a legislative hearing, see 1 K. DAVIS, *supra* note 238, §§ 7.02, 7.06-.07.

278. *See* Bonfield, *Representation for the Poor in Federal Rulemaking*, 67 MICH. L. REV. 511 (1969). Bonfield suggests various methods to involve the poor in rulemaking and to make administrative agencies more responsive to their participation. A similar approach, designed to involve the elderly, would better inform rulemakers about the needs and interests of the elderly. *See also* Freedman, *The Administrative Process and the Elderly*, 46 TEMP. L.Q. 511 (1973).

make appropriate findings to justify issuance of conditional certification, or in other situations where agencies fail to discharge their duties. Suits can be brought, for example, to enjoin a proposed certification[279] or to permit residents to participate in the administrative process.[280] While these proposals involve some practical difficulties,[281] the potential benefits obtainable from such actions are so significant that their implementation is necessary.

B. *Tort Liability*

A nursing home undertakes to provide care and medical services to its residents. If it fails to do so, or does so negligently, and a patient dies or is injured, the home is liable in tort.[282] Similarly, the home may be liable for injuries intentionally caused to residents of the home.[283] Generally, however, tort liability is unsatisfactory as an en-

279. Residents of a nursing home should be able to enjoin an HEW decision to certify a facility that has deficiencies where there has not been a finding that the deficiencies do not adversely affect patient safety. This is analogous to actions to enjoin issuance of a license to a power plant if an environment impact statement has not been prepared. *See* 2 F. GRAD, TREATISE ON ENVIRONMENTAL LAW § 903(b) (1974).

280. Where decertification is proposed, residents should be notified and should be allowed to participate in hearings or other administrative proceedings. *See* discussion notes 211-12, 242 *supra*.

281. For example, jurisdictional problems may arise. Suits brought under 28 U.S.C. § 1361 (1970) may be met by objections that HEW has no clear ministerial duty to provide the relief requested. Where the existence of such a duty is in question, however, the court should assume jurisdiction and, if it concludes there is no duty, deny relief on the merits. *See* Hahn v. Gottlieb, 430 F.2d 1243 (1st Cir. 1970). 28 U.S.C. § 1331 (1970) requires that in excess of $10,000 be in controversy for federal question jurisdiction and it may not be possible to establish that such a sum is involved. *See* C. WRIGHT, HANDBOOK OF THE LAW OF FEDERAL COURTS §§ 32-36 (2d ed. 1970). Because a patient's very life may be at stake and because of the high cost of medical care, however, the jurisdictional amount may be met. *See* Martinez v. Richardson, 472 F.2d 1121 (10th Cir. 1973); Bass v. Rockefeller, 331 F. Supp. 945, 952 n.6 (S.D.N.Y. 1971). The cases are divided as to whether the Administrative Procedure Act provides an independent basis of jurisdiction. *Compare* Citizens Comm. for Hudson Valley v. Volpe, 425 F.2d 97 (2d Cir.), *cert. denied*, 400 U.S. 949 (1970), *with* Arizona State Dep't of Pub. Welfare v. HEW, 449 F.2d 456 (9th Cir. 1971).

282. The nursing home is generally said to have legal rights and responsibilities similar to a hospital. *See generally* Gray v. Carter, 100 Cal. App. 2d 642, 224 P.2d 28 (Ct. App. 1950); Facey v. Merkle, 146 Conn. 129, 148 A.2d 261 (1959); Ferguson v. Dr. McCarty's Rest Home, Inc., 335 Mass. 733, 142 N.E.2d 337 (1957). Although charitable and governmental immunities once prevented successful suits against nonprofit hospitals or health care facilities, those doctrines retain little vitality at present. R. GOODMAN & L. GOLDSMITH, MODERN HOSPITAL LIABILITY—LAW & TACTICS § 7.3 (1974), *citing* Hanson & Stromberg, *Hospital Liability for Negligence*, 21 HASTINGS L.J. 1 (1969). Even where charitable immunity remains viable, it is not available to the 70 percent of nursing homes that operate for a profit.

283. A health facility may be vicariously liable for the negligence of an employee under the doctrine of respondeat superior, if the negligent act occurred during the course of the employment or while in furtherance of the employer's interests. Jefferson Hosp., Inc. v. Van Lear, 186 Va. 74, 41 S.E.2d 441 (1947); HOSPITAL LAW MANUAL *Principles of Hospital Liability* ¶¶ 1-2 (Aspen Systems Corp., publication 1972); NURSING HOME LAW MANUAL, *supra* note 42, *Negligence* ¶ 2-2. There is generally no vicarious liability for the negligent acts of special or private duty nursing personnel. *See* Kamps v. Crown Heights Hosp., 277 N.Y. 602, 14 N.E.2d 184 (1938). One recent case, however, has held that the hospital has a duty to supervise nonemployee professionals. *See* Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).

forcement device because death or injury must occur before liability arises. Tort remedies are useful, however, to the extent that fear of tort liability may induce a home to comply with standards of care independently of public enforcement efforts. Admittedly, fear of tort liability has a negative aspect as well. Homes may be overly cautious in the application of restraints and may refuse to permit residents to move about the home freely or to leave the home.[284]

1. *Negligence.* A patient seeking to establish liability for negligence must prove that the harm suffered was caused directly by the breach of a duty owed to him by the home.[285] In the few cases dealing with nursing home liability, courts have held that a nursing home has a duty to treat and care for patients.[286] In determining whether this duty of reasonable care has been met, a patient's age and physical and mental conditions are considered.[287] Because of the frailty of many nursing home patients, a high standard of care normally has been imposed on nursing homes.[288]

Federal and state quality standards, such as the federal conditions of participation and the LSC, increasingly are being used to determine whether reasonable care was exercised.[289] These standards provide

284. Where necessary to prevent injury, however, health care facilities have been required to use restraints. *See* Dusine v. Golden Shores Convalescent Center, Inc., 249 So. 2d 40 (Fla. Ct. App. 1971); Lathan v. Murrah, Inc., 121 Ga. App. 554, 174 S.E. 2d 269 (1970).

285. *See* discussion note 282 *supra.*

286. In Hendricks v. Sanford, 216 Ore. 149, 337 P.2d 974 (1959), the court found that a complaint for serious injury caused by bedsores stated an adequate cause of action for negligent failure to give proper care.

Some constitutional protections have received recognition in the case law. *See* Donaldson v. O'Connor, 493 F.2d 507 (5th Cir.), *vacated*, 95 S. Ct. 2486 (1975) (involuntarily committed mental patient has constitutional right to treatment); Wyatt v. Stickney, 344 F. Supp. 373 & 387 (M.D. Ala. 1972), *aff'd sub. nom.*, Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) (involuntarily institutionalized mental patients have a right to adequate treatment). With regard to these constitutional protections, it must be noted that the involuntary nature of institutionalization has been a major factor in the decisions and that the majority of patients in nursing homes enter on a voluntary basis. In addition, only 8 percent of nursing homes are publicly controlled, INTRODUCTORY REP., *supra* note 3, at 22, and thus clearly meet the state action requirement of the 14th amendment.

287. *See* Dunahoo v. Brooks, 272 Ala. 87, 128 So. 2d 485 (1961) (nursing home found negligent when infirm, 94-year-old patient became entangled in loose electric light cord and fell, injuring herself); Ferguson v. Dr. McCarty's Rest Home, Inc., 335 Mass. 733, 142 N.E.2d 337 (1957) (jury could reasonably find negligence when semiparalyzed, 89-year-old patient was burned by contact with a hot radiator next to her bed); Lagrone v. Helman, 233 Miss. 654, 103 So. 2d 365 (1958) (duty of nursing home operator is to exercise reasonable care for patients, consistent with their age and physical condition).

288. *See* Dunahoo v. Brooks, 272 Ala. 87, 128 So. 2d 485 (1961); Dusine v. Golden Shores Convalescent Center, Inc., 249 So. 2d 40 (Fla. Ct. App. 1971); Lathan v. Murrah, Inc., 121 Ga. App. 554, 174 S.E.2d 269 (1970). This higher standard of care is discussed in NURSING HOME LAW MANUAL, *supra* note 42, *Negligence* ¶ 1-3.

289. *See* Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965) (state regulations and national hospital accreditation standards relevant in determining standard of care); HOSPITAL LAW MANUAL, *supra* note 283, *Principles of Hospital Liability* ¶ 1.

the clearest measure available. Their use as standards to measure the reasonableness of care in a negligence context is justified because they are intended to protect patients.

> Where legislation prescribes a standard of conduct for the purpose of protecting life, limb, or property from a certain type of risk, and harm to the interest sought to be protected comes about through breach of the standard from the risk sought to be obviated, then the statutory prescription will at least be considered in determining civil rights and liabilities.[290]

In an analogous setting, city housing regulations have been used as the measure of whether a landlord is negligent in failing to maintain an apartment safely.[291] Federal and state standards also may be used by a home to disprove negligence, and in several cases, homes have pointed to the lack of specific standards or to their compliance with existing standards to establish they had not been negligent.[292]

Another problem which arises in nursing home negligence cases is proof of causation. Often an injury will occur when a patient is left unattended. In these situations, homes have escaped liability because courts found the home's action not to be the proximate cause of injury or have found the patient to be contributorily negligent.[293] In addition, some injuries suffered by nursing home residents are nontraumatic and proximate causation is difficult to establish in such cases.

2. *Intentional Torts.* Homes are also liable for intentional actions of employees. For example, in *Big Town Nursing Home, Inc. v. Newman,*[294] a home was found liable for false imprisonment when a patient was detained by the home against his will, in spite of numerous efforts to leave. If a patient is injured by an employee who is physically abusive, or restrained for the convenience of staff rather than medical necessity, the home may be liable in tort. Homes also may be liable for undertaking procedures without the informed consent of the residents[295] and for such actions as retaliatory transfers[296] or other inter-

290. F. HARPER & F. JAMES, 2 THE LAW OF TORTS § 17.6 (1956). *See also* W. PROSSER, LAW OF TORTS § 36 (4th ed. 1971).

291. *See* Whetzel v. Jess Fisher Management Co., 282 F.2d 943 (D.C. Cir. 1960).

292. In Nichols v. Green Acres Rest Home, Inc., 245 So. 2d 544 (La. Ct. App. 1971), a nursing home that was in full compliance with the state's standards was held not liable for the death of an unattended elderly patient.

293. *See generally* Gray v. Carter, 100 Cal. App. 2d 642, 224 P.2d 28 (Ct. App. 1950); Facey v. Merkle, 146 Conn. 129, 148 A.2d 261 (1959); Ferguson v. Dr. McCarty's Rest Home, Inc., 335 Mass. 733, 142 N.E.2d 337 (1957).

294. 461 S.W.2d 195 (Tex. Civ. App. 1970).

295. It is well settled that a patient's consent must be secured before an operation or other treatment can be performed. *See generally* W. PROSSER, *supra* note 290, § 32, at 165-66; Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1970); Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396 (1967). In most instances, the patient's consent should be required for the use of restraints. As one court recently noted: "[e]very human being of adult years and sound

ference with the exercise of a resident's rights. These problems have been addressed in the patients' bill of rights and a number of state regulations.

3. *Damages.* A troublesome aspect of tort liability is that of assessing damages, particularly for those patients who have outlived their actuarial life expectancy. The traditional method of assessing personal injury damages, other than for pain and suffering and medical expenses, is to determine what loss of future earning power the injured party will sustain.

> The jury should be directed to find, first, the number of years of life which the plaintiff could normally have expected to have before him at the present time if he had not been injured, and, second, his probability of life at the present time, in his injured condition. They should then be directed to fix the plaintiff's deprivation of future earning power on the former basis of normal expectancy . . . and to estimate the anticipated expenses and the compensation for future pain and suffering on the latter basis of actual probable length of life.[297]

While this rule may result in lower damage awards for elderly retirees than for younger persons, substantial awards nevertheless may be obtained.[298] An elderly person's death may result in the loss of substantial social security, pension, or other benefits, and these losses are compensable.[299] In addition, damages for pain and suffering and medical expenses can be obtained and punitive damages may be awarded.[300]

C. *Contract*

Private causes of action based on contract law have had a somewhat limited usefulness for the nursing home patient. They may be

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mind has a right to determine what shall be done with his own body. . . . To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential." Canterbury v. Spence, 464 F.2d 772, 780-81 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). *See also* Wilkinson v. Vossey, 110 R.I. 606, 295 A.2d 676 (1972); NURSING HOME LAW MANUAL, *supra* note 42, *Consents*, ¶ 6-2, at 19 ("To restrain without sufficient reason to do so is practically equivalent to false imprisonment or the performance of an intentional battery without consent.").

296. On retaliatory transfers and their negative effect on patients, see discussion note 123 *supra*.

297. C. MCCORMICK, HANDBOOK ON THE LAW OF DAMAGES § 86 (1935).

298. The damage award based on actuarial statistics need not be negligible for an elderly person. The life expectancy at age 65 is now 14.8 years (13.0 for men; 16.5 for women). SENATE SPECIAL COMM. ON AGING, DEVELOPMENTS IN AGING: 1972 & JANUARY-MARCH 1973, S. REP. No. 93-147, 93d Cong., 1st Sess., XVIII (1973).

299. For a general discussion of the damages available in such an action, see D. DOBBS, HANDBOOK ON THE LAW OF REMEDIES §§ 8.1-.6 (1973); Annot., 52 A.L.R.3d 1289 (1973).

300. D. DOBBS, *supra* note 299, § 3.9; Annot., 27 A.L.R.3d 1274 (1969); Annot., 20 A.L.R.2d 276 (1951).

helpful, however, in compelling compliance with quality standards and enforcing patient rights.

1. *Life Care Contracts.* For the most part, contract theories have been confined to cases concerning the life care contract, an arrangement whereby the patient turns over all of his assets to the nursing home in exchange for a promise that he will be cared for completely until death. The danger with such a contract is twofold: the patient is deprived of substantially all future bargaining power over the quality of care he receives, and the facility receives compensation which is inversely proportioned to the patient's longevity.

The life care contract has such potential for abuse that its use has been outlawed by some jurisdictions and strictly regulated by others. New York State, for example, specifically prohibits the use of a life care contract,[301] while California has imposed conditions which must be met if life care contracts are to be utilized.[302] In the absence of such statutes, however, courts generally have upheld life care contracts,[303] even where the amount received by the facility greatly exceeded the value of services rendered.[304]

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301. 10 N.Y.C.R.R. § 730.2(f) (1975), states: "The operator shall make no arrangement for prepayment of basic services exceeding three months." Section 730.3(2)(b) provides "the operator shall not enter into any contract . . . for life care of the patient." In addition, the nursing home may accept only those patients "for whom it can provide adequate care." *Id.* § 730.2(b). While "adequate care" is not defined, this regulation could be used as one possible basis of a statutory duty of care to impose tort liability on the nursing home. *See* text & note 286 *supra.*

302. CAL. WELF. & INST. CODE § 16300 (West 1972). The California law requires that a person or organization may enter into a life care contract with an aged person only if it has received a written license or permit, has been granted a certificate of authority by the state, and maintains financial reserves covering all life care agreements. *Id.* §§ 16300, 16304. Any applicant for a certificate of authority may be required to file and maintain a surety bond "in an amount satisfactory to the department, conditioned that the principal will faithfully perform all obligations . . . pursuant to the certificate . . . to and for the use and benefit of all persons who may be injured or aggrieved by the failure of the principal to perform any such obligation." *Id.* § 16302. Another means of enforcement provided by the code is the transferor's lien, by means of which the department may execute a lien on all real property of the certificate holder when necessary to secure the performance of his obligations. The lien is released upon proof of complete performance of the obligations. *Id.* § 16301. In case of liquidation, life care agreements have priority over all assets, *id.* § 16305, and the life care agreement must show the value of all property transferred and all services to be provided. *Id.* § 16306. While there has not been a great deal of litigation concerning the California law, it has been held that the requirement of obtaining a certificate of authority applies to noninstitutional care. *See* Stenger v. Anderson, 66 Cal. 2d 970, 429 P.2d 164, 59 Cal. Rptr. 844 (1967).

303. *See* Caldwell v. Basler, Inc., 225 Cal. App. 2d 327, 37 Cal. Rptr. 307 (Ct. App. 1964); Baldwin v. Grymes, 232 Md. 470, 194 A.2d 285 (1963); Henry Keep Home v. Moore, 198 Okla. 198, 176 P.2d 1016 (1947).

304. *See* Wilson v. Dexter, 135 Ind. App. 247, 192 N.E.2d 469 (1963) (home for aged not barred from full performance where $20,000 had been given and the patient had lived in the facility only 42 days, receiving services valued at $1000); Fidelity Union Trust Co. v. Reeves, 96 N.J. Eq. 490, 125 A. 582 (Ch. 1924), *aff'd,* 98 N.J. Eq. 412, 129 A. 922 (Ct. Err. & App. 1925) (per curiam) (home entitled to receive $30,000 estate that had been left to patient shortly before death, where the contract had been fairly entered into and the home had fulfilled its terms).

Life care contracts often include a "probationary period," during which the patient begins residence in the facility. Difficulty in the interpretation of such contracts has arisen where death of the resident occurred during the probationary period. Where the contract was silent as to the effect of death during this period, only one case has held that the nursing home is entitled to retain the property which was the subject of the contract.[305] For the most part, the courts have found that no life care contract was entered into if death occurred during the probationary period, since a stay beyond the trial period was a condition precedent to the contract.[306] In such a situation, the nursing home is only compensated for actual expenses incurred in caring for the patient.[307]

Proceedings to enforce life care contracts are generally commenced by the nursing home.[308] Actions by residents, however, can be used as an enforcement device to compel the home to provide promised benefits.[309] This enforcement device has not received much attention, probably due to the reluctance of a patient who is wholly dependent on a facility to assert rights against it.[310] A deceased patient's estate would be under no such constraint, however, and such an action should be considered when the decedent has received poor treatment. Such actions might have a beneficial deterrent impact on nursing home operators.

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305. *See* Dodge v. New Hampshire Centennial Home for Aged, 95 N.H. 472, 67 A.2d 10 (1949).

306. *See* First Nat'l Bank v. Methodist Home for the Aged, 181 Kan. 100, 309 P.2d 389 (1957); Old Peoples Home of Ill. Conference of Methodist Episcopal Church v. Miltner, 149 Kan. 847, 89 P.2d 874 (1939); Farrand v. Redington Memorial Home, 270 A.2d 871 (Me. 1970); Brydges v. Home for the Aged, 373 Mich. 408, 129 N.W.2d 869 (1964); Kirkpatrick Home for Childless Women v. Kenyon, 119 Misc. 349, 196 N.Y.S. 250 (Sup. Ct. 1922), *aff'd*, 206 App. Div. 728, 199 N.Y.S. 851 (App. Div. 1923) (per curiam); Smith v. Eliza Jennings Home, 176 Ohio St. 351, 199 N.E.2d 733 (1964); Lyon v. Williamette Lutheran Homes, Inc., 240 Ore. 56, 399 P.2d 895 (1965).

307. *See* First Nat'l Bank v. Methodist Home for the Aged, 181 Kan. 100, 309 P.2d 389 (1957); Farrand v. Redington Memorial Home, 270 A.2d 871 (Me. 1970); Smith v. Eliza Jennings Home, 176 Ohio St. 351, 199 N.E.2d 733 (1964).

308. *See* authorities cited notes 303-04, 306 *supra*. The nursing facility also has been successful in recovering where assets were fraudulently concealed at the time of admission. *See* German Aged People's Home v. Hammerbacker, 64 Md. 595, 3 A. 678 (1886); Old Men's Home v. Lee's Estate, 191 Miss. 669, 4 So. 2d 235 (1941).

309. In Bruner v. Oregon Baptist Retirement Home, 208 Ore. 502, 302 P.2d 558 (1956), the court granted a resident's claim for specific performance of a life care contract and damages, even though the cost of the care far exceeded the original consideration paid by the patient.

310. *See* Annas & Healey, *The Patient Rights Advocate: Redefining the Doctor-Patient Relationship in the Hospital Context*, 27 VAND. L. REV. 243 (1974).

> Because a sick person's first concern is to regain his health, he is willing to give up rights that otherwise would be vigorously asserted. Moreover, the doctor-patient relationship as it exists in the hospital—where the most critical decisions are made and where most people receive their primary care—effectively removes the patient from any participation in the medical decision-making process.

Id. at 245.

2. *Third-Party Beneficiary.* A nursing home resident whose care is paid for by Medicaid or Medicare may be a third-party beneficiary of the provider agreement between the nursing home and the federal government. While there appear to be no cases where nursing home residents have sued as third-party beneficiaries,[311] the right of utility users,[312] indigent persons unable to pay for medical care,[313] and other intended beneficiaries of public contracts[314] to sue as third-party beneficiaries has been upheld. The intended beneficiaries of the provider agreement are the individuals residing in the home who are eligible for Medicaid or Medicare. Where the care provided fails to meet applicable standards, the resident should be entitled to sue the home as the third-party beneficiary of the provider agreement.[315] Recognition of this right would enable nursing home residents to sue homes that fail to provide adequate care and would free them from dependence on public enforcement efforts.[316]

3. *Breach of Warranty.* Nursing home residents generally contract with the home in which they reside for the provision of care. As

311. In one case, the right of a hospital patient to sue as a third-party beneficiary has been upheld. *See* Gooch v. Buford, 262 F. 894 (6th Cir. 1920) (husband and hospital entered into a contract designed to provide special hospital services for the wife).

312. *See* Independent School Dist. v. Le Mars City Water & Light Co., 131 Iowa 14, 107 N.W. 944 (1906); Farnsworth v. Boro Oil & Gas Co., 216 N.Y. 40, 109 N.E. 860 (1915).

313. Several courts have held that the Hill-Burton Act, 42 U.S.C. §§ 291 to 291*o*-1 (1970), "evidences a design" to benefit persons unable to pay for medical services. *See* Saine v. Hospital Authority, 502 F.2d 1033 (5th Cir. 1974); Euresti v. Stenner, 458 F.2d 1115 (10th Cir. 1972); Organized Migrants in Community Action, Inc. v. James Archer Smith Hosp., 325 F. Supp. 268 (S.D. Fla. 1971); Cook v. Ochsner Foundation Hosp., 319 F. Supp. 603 (E.D. La. 1970). *But see* Stanturf v. Sipes, 224 F. Supp. 883 (W.D. Mo. 1963), *aff'd*, 335 F.2d 224 (8th Cir. 1964), *cert. denied*, 379 U.S. 977 (1965). *See also* Note, *Implying Civil Remedies from Federal Regulatory Statutes*, 77 HARV. L. REV. 285 (1963).

314. *See generally* L. SIMPSON, HANDBOOK OF THE LAW OF CONTRACTS § 118 (2d ed. 1965). In Shell v. Schmidt, 126 Cal. App. 2d 279, 272 P.2d 82 (Ct. App. 1954), *cert. denied*, 348 U.S. 916 (1955), veterans who had purchased homes in reliance on a contractor's promise to the government to comply with building plans and specifications were held entitled to sue for damages for breach of this contract, despite the fact that other remedies were available. In public construction contracts, where the contractor promises to pay for damages to buildings abutting the area under construction, owners of the abutting property may recover as third-party beneficiaries of the construction contract. *See* Pennsylvania Cement Co. v. Bradley Contracting Co., 7 F.2d 822 (2d Cir. 1925); Rigney v. New York Cent. & H.R.R., 217 N.Y. 31, 111 N.E. 226 (1916).

315. Traditional contract law has seen the growth of the third-party beneficiary theory. It is no longer necessary that the beneficiary meet a strict privity requirement in order to enforce the contract. *See generally* 4 A. CORBIN, CORBIN ON CONTRACTS §§ 773-81 (1951, Supp. 1971). However, a third party beneficiary still must demonstrate that the contract created reasonable expectations on his part which induced him to change his position in reliance on it. In addition, the promised performance must benefit the third party in one of two ways: "First, it may be a performance that will in itself create new and beneficial legal relations between him and other persons; and secondly, without affecting his legal relations at all, it may beneficially affect his physical, social, and economic relations with the surrounding world." *Id.* § 775.

316. Even without the third party beneficiary theory, however, a nursing home patient should be able to obtain relief for violation of a statute. This right has been recog-

a result of state and federal standards governing the quality of care in nursing homes, an implied warranty of compliance with these codes may provide nursing home residents with a basis for a claim. While these agreements seldom mention state and federal standards, residents are entitled to expect that the care contracted for will be of decent quality, as measured by these standards. By way of analogy, landlords in many jurisdictions are held to warrant that dwellings they offer for occupancy comply with local housing codes.[317] There is no reason why this analogy should not extend to nursing home operators, entitling residents to normal contract remedies where the warranty has been breached.

4. *Illegal Contract.* Nursing home residents also can assert that a home which is unlicensed or fails to provide care conforming to state and federal standards should be barred from seeking any contract benefits. Thus, a failure to meet standards of care or licensing requirements may be raised as a defense in an action by a home for payment for services rendered.[318] This defense was recognized in *Culverhouse v. Atlanta Association for Convalescent Aged Persons, Inc.*,[319] in which a nursing home was not permitted to recover because the nursing home's administrator was not licensed as required by state law. While not a means of affirmatively inducing compliance with safety and care standards, this defense may prevent the noncomplying home from recovering from the patients so long as the deficiencies go unremedied.

5. *Remedies.* The full range of contract remedies should be available to nursing home patients seeking to compel compliance with statutorily imposed quality standards.[320] Actions for declaratory judgment[321] and specific performance are especially useful for this pur-

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nized in the field of housing law. *See* Barber v. White, 351 F. Supp. 1091 (D. Conn. 1972) (persons residing in low-rent public housing entitled to declaratory and injunctive relief to prevent raising of their rents in excess of federal limits). *See also* Marshall v. Lynn, 497 F.2d 643 (D.C. Cir. 1973); Thompson v. Washington, 497 F.2d 626 (D.C. Cir. 1973).

317. *See* Javins v. First Nat'l Realty Corp., 428 F.2d 1071 (D.C. Cir. 1970); Steele v. Latimer, 214 Kan. 329, 521 P.2d 304 (1974); Pines v. Perssion, 14 Wis. 2d 590, 112 N.W.2d 409 (1961). *See also* Moskovitz, *Rent Withholding and the Implied Warranty of Habitability—Some New Breakthroughs*, 4 CLEARINGHOUSE REV. 49 (1970).

318. *See* D. DOBBS, *supra* note 299, § 13.5. In the residential lease situation, the illegal contract theory has been applied to declare a lease void and unenforceable where housing code violations existed at the inception of the lease. *See* Brown v. Southhall Realty Co., 237 A.2d 834 (D.C. Ct. App. 1968) (action by landlord for possession for nonpayment of rent).

319. 127 Ga. App. 574, 194 S.E.2d 299 (1972) (violation of legislation primarily intended to protect the public from improper nursing home administration renders the contract void).

320. For a general discussion of the use of civil actions to remedy violations of a statute, see Note, *supra* note 313.

321. In the health law field, declaratory judgments have been successfully used to enforce compliance with provisions of the Hill-Burton Act, 42 U.S.C. §§ 291 to 291*o*-1 (1970). *See* authorities cited note 313 *supra.*

pose. A suit for a declaratory judgment can clarify the home's obligation to provide certain services, to include certain services within the basic charge rather than charging separately, and to comply with state and federal standards. Similarly, a suit for specific performance may produce an order compelling a facility to provide care at a given rate or to provide care which conforms with state and federal standards.[322] A suit for damages can compensate a patient for the additional costs of obtaining the care which was promised but not provided.[323]

D. *Other Actions by Residents*

Although private actions are highly desirable supplements to public enforcement, such actions have their own limitations. Most nursing home residents will be reluctant to involve themselves in such actions. Fear, physical frailty, and a lack of familiarity with the courts all contribute to this problem.[324] Lawyers may be difficult to obtain. Few private practitioners are likely to be interested in such actions, and few legal services or other public interest lawyers are familiar with the problems of the elderly. Moreover, many of the suits will be complex, time consuming, and expensive.

For these reasons, additional alternative enforcement devices should be developed to vindicate patient rights. Needed are enforcement mechanisms which will be easily accessible to patients, speedy, fair, and inexpensive. A model worthy of consideration is the grievance procedure promulgated by the Department of Housing and Urban Development, which requires each local housing authority to establish grievance procedures which tenants may utilize to resolve complaints by or against the authority.[325] Each authority must establish a mechanism for submission of complaints and must give the complainant an opportunity for a hearing which must be presided over by a hearing officer or a panel consisting of tenants, authority employees, and impartial persons. Although this procedure is not perfect, it has given public housing tenants an opportunity for reasonably speedy resolution of complaints and has not been burdensome to housing authorities. Promulgation of a similar procedure for nursing homes would provide a useful vehicle for resolution of most patient complaints and would

322. *See* D. DOBBS, *supra* note 299, § 12.2. Specific performance may be refused because court supervision would be difficult or prolonged. *Id.* § 12.2, at 796. For a discussion of specific enforcement of life care contracts, see note 309 *supra.*

323. *See* D. DOBBS, *supra* note 299, §§ 3.1-.9, 8.1-.3.

324. *See generally* SUPPORTING PAPER No. 1, *supra* note 51, at 191-93; Annas & Healey, *supra* note 310.

325. 39 Fed. Reg. 39287 (1974). An earlier version of these regulations was upheld in Housing Authority v. United States Housing Authority, 468 F.2d 1 (8th Cir. 1972), *cert. denied,* 410 U.S. 927 (1973).

be especially valuable for prompt resolution of alleged violations of patient rights.

A similar solution would be to designate arbitrators to resolve disputes involving alleged violations of patients' rights. Arbitration has been employed successfully to resolve disputes in a variety of settings and might work in this context. Indeed, arbitration might well be utilized to resolve disputes relating to whether provider agreements should be terminated. This is preferable to the lengthy administrative and judicial process now used. Other solutions doubtless are available, and experiments should be undertaken to explore satisfactory alternatives.

E. *Opening Nursing Homes to the Public*

Nursing home patients very often are reluctant to advocate improvements in the care they receive and many are incapable of advocating for themselves. In addition, many nursing home residents have no families[326] or the families are reluctant to become involved in efforts to improve nursing home conditions for personal reasons or because of fears that such efforts will be met by staff retaliation against patients.[327] The shortage of advocates for nursing home patients is one reason why abuses are so prevalent.

To remedy this situation, it is necessary to increase public presence in nursing homes, not just during visiting hours, but at all times. This public presence would add greatly to the capacity of enforcement agencies to learn of deficiencies in nursing homes and would serve to check excessive sedation, needless physical restraint, and other violations of patients' rights. In many areas, programs already exist in which volunteers are sent to nursing homes to visit patients. These programs are helpful, but are not oriented toward remedying deficiencies. More effective are the programs established by private advocacy organizations to monitor conditions in nursing homes.[328] While these programs often rely on volunteers to visit nursing homes, their objective is to improve conditions instead of simply visiting with patients. Nursing home operators, reluctant to permit "troublemakers" in their

326. INTRODUCTORY REP., *supra* note 3, at 16.
327. *See* text accompanying notes 119-20 *supra*.
328. One such organization is Citizens for Better Care, a nursing home advocate group which received authorization to critically evaluate services and facilities and to uncover abuses in nursing homes in Wayne County, Michigan. The group's recommendations are found at Nursing Home Regulations Description and Recommendations (1974) (unpublished report available from Citizens for Better Care).

The case of Citizens for Better Care v. Reizen, 51 Mich. App. 454, 215 N.W.2d 576 (1974), for example, demonstrates an advocate group's ability to judicially require disclosure of data about nursing homes.

homes, sometimes bar such groups from entering their facilities. While the patients' bill of rights regulations do not explicitly forbid such obstructive tactics, they do enhance the ability of such groups to enter private nursing homes to meet with residents and receive complaints.[329]

In six states, nursing home ombudsmen programs have been established with the objective of improving conditions in nursing homes by establishing offices to receive and resolve complaints.[330] Funded by HEW, all but one of these programs are associated with state government, although not with the agency having enforcement responsibilities over nursing homes. Although the powers of these programs vary, none is empowered to impose fines or other sanctions on noncomplying facilities. Rather, they act as complaint and information centers. Problems they cannot resolve are referred to the state enforcement agency for action. In addition, they issue reports on nursing home problems and make legislative and administrative recommendations for their resolution.

More programs should be established to monitor nursing homes. Operated by private community action agencies or by governmental entities such as consumer affairs offices or offices for the aging, such programs should visit nursing homes on a regular basis to ensure that patients are well treated and that standards are observed.

CONCLUSION

The profoundly disturbing conditions found in nursing homes will not be remedied easily. Years of public apathy have left a legacy of isolation, neglect, and abuse which will be eradicated only by sustained effort. Laws governing patient care and financial reimbursement must be strengthened and consolidated, and inspection and enforcement must improve dramatically. Public enforcement agencies need to be strengthened, and use must be made of a broad range of inspection and enforcement devices. Moreover, patients and the public must become more involved in the effort to improve nursing home conditions. Unless these changes occur and unless alternatives to nursing home care are made available, nursing homes will continue to be symbols of this nation's neglect of the elderly.

329. *See* discussion note 121 *supra.*
330. *See* discussion note 51 *supra.*