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Nursing Homes in Montgomery County: Regulatory Framework and Issues Impacting the Quality of Care

Chitra Kalyandurg
Kaitlyn Simmons

Office of Legislative Oversight
Montgomery County, Maryland

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OLO Report 2023-7 **Executive Summary** **July 25, 2023**

The County Council requested this Office of Legislative Oversight report to examine the universe of nursing homes in Montgomery County, how state and local laws impact the operation of County nursing homes, and how the Council can better support nursing homes and their residents. Nursing homes serve two important niches in long-term care: a place to receive full-time health care and a home. While home and community-based services are important long-term care options, nursing homes are critical for individuals who have complex care needs or lack the resources to receive care at home. The COVID-19 pandemic took an enormous toll on nursing home residents and staff and shed light on long-standing issues that have plagued nursing homes for decades, including:

- **Critical staff shortages** and **chronic understaffing**;
- Widespread and persistent **health and safety deficiencies**; and
- **Racial and ethnic disparities in the quality of care** in nursing homes.

Regulations and Enforcement of Nursing Homes

The County has little oversight and enforcement authority over nursing homes. The primary form of regulation for nursing homes are the federal requirements for participation in Medicare and Medicaid. The Centers for Medicare and Medicaid Services (CMS) enforce federal regulations and states help determine nursing homes' compliance through facility surveys and inspections. Decades of underfunding and staff shortages have caused inspections to fall behind in many states, including in Maryland. According to CMS data, 80% of nursing homes in Maryland have gone at least 16 months without a standard survey.

History of County Surveys

Until 2021, the County had greater oversight of nursing homes in the County. An MOU between the County and the Maryland Department of Health allowed County surveyors to conduct nursing home inspections on behalf of the State. The State terminated the MOU on July 1, 2021, and the MD Office of Health Care Quality (OHCQ) assumed responsibility of inspections.

Nursing Home Quality and Resident Outcomes

CMS measures the quality of care in nursing homes using its "Five Star Rating System" (1 star being the lowest and 5 stars being highest). Research shows that nursing homes owned by for-profit companies are associated with lower quality of care and poorer resident outcomes compared to non-profit facilities. The table on the next page shows that for-profit nursing homes in the County have a higher ratio of homes with 1- or 2-star ratings compared to non-profit homes in the County.

Federal CMS Ratings and Ownership Type for Nursing Homes in Montgomery County

Overall Rating	Total # of nursing homes	For-profit #	Non-profit #
4 or 5	18	9	9
3	6	5	1
2	5	4	1
1	5	5	0
Total	**34**	**23**	**11**

Racial and ethnic disparities in quality of care and resident outcomes. Decades of research show that Black nursing home residents receive lower quality of care and experience worse health outcomes when compared to White residents. Decades of systemic racism and discriminatory laws and practices in the United States have negatively impacted where and how communities of color, particularly Black communities, live, work, go to school, and access healthcare. These social determinants of health have been key drivers of poor health outcomes consistently seen in communities of color. Data show that health disparities accumulate over the course of a lifetime and create inequities in patient outcomes in nursing homes. When compared to White residents, Black nursing home residents are more likely to be physically restrained, hospitalized, treated for pain less often, vaccinated less often, and report lower quality of life.

Studies find nursing homes with the lowest % of White residents were more than 2x as likely to have COVID-19 cases/deaths as homes with the highest % White residents.

Nursing Home Workforce

The primary challenge facing nursing homes in Montgomery County is the healthcare workforce crisis, which the pandemic has exacerbated. Studies show that residents in understaffed facilities are unable to get assistance with personal care, are more likely to be inappropriately medicated, and are likely to experience significant harm compared to facilities with adequate staffing. Factors contributing to nurse shortages in the County include:

- Crushing workloads that lead to high levels of burnout and staff turnover; in the average nursing home in the County, **47% of nursing home staff are employed for less than two years**;
- Physically demanding and low paying jobs that lead many nurses to leave the field; **the median annual salary for a Geriatric Nursing Assistant (GNA) in a nursing home in Montgomery County is only $34,026**; and
- Shortage of faculty, testing backlogs, and stricter state certification requirements that constrain nurse training and placements into nursing homes; **Maryland is one of the only states that requires a GNA certification to work in nursing homes.**

Factors contributing to nurse shortages in the County disproportionately impact women of color and immigrants, who make up most of the nursing home workforce.

Nursing Home Financing and Ownership

Since the 2000s, private equity (PE) firms have increasingly invested in nursing homes, employing various strategies to lower costs and make nursing homes profitable, such as lowering labor costs and raising prices of overall care. Research shows that health outcomes in PE-owned facilities are worse compared to facilities under other ownership. The Washington Post identified two nursing homes in Montgomery County as owned by PE firms: Peak Healthcare Facility at Sligo Creek and Fox Chase Rehabilitation Center.

Supports for Nursing Home Residents and Older Adults in the County

Montgomery County Long-Term Care (LTC) Ombudsman

The LTC Ombudsman is a federally mandated program which advocates on behalf of long-term care residents, including nursing home residents, and works to resolve complaints about quality of care and other issues. The LTC Ombudsman is neither a regulatory nor enforcement entity. **The COVID-19 pandemic significantly impacted the County's LTC Ombudsman's operations.** The program has suffered staff and volunteer shortages which has made it difficult to conduct regular in-person visits to long-term care facilities in the County. Prior to the pandemic, the program had almost 50 volunteers and currently, it has eight active volunteers.

Gaps in Services for Nursing Home Residents. There are gaps in services in the County for nursing home residents, including gaps in transportation, mental health services, and religious services. County staff shared concerns that older adults in County homes are often left out of programs and activities the County provides for older adults, due in part to an assumption that nursing home residents receive services through their respective facilities. Further, the County's African American Health Program (AAHP) has observed that many older Black residents in the County feel they do not have the same access to County programs as White residents do, nor do they feel they receive culturally appropriate services and care.

Affordable Housing for Older Adults. Studies show that older adult renters who are housing cost burdened are four times more likely to move to a nursing home compared to older homeowners who are not cost burdened. In Montgomery County, nearly 60% of older adult renters are housing cost-burdened compared to 26% of older adult homeowners. Increasing access to social and economic supports, such as affordable housing for seniors, can help older adults choose the best option for aging based on their health needs. Research suggests that increased access to affordable housing for older adults could reduce the rate of unnecessary nursing home admissions.

OLO Recommendations

The County has little oversight and enforcement authority over nursing homes. Federal and state regulations comprise the bulk of the regulatory framework for nursing homes, with enforcement and oversight responsibilities generally split between federal and state agencies. However, the County can play an important role in supporting nursing homes in the County and their residents:

- By evaluating, supporting and/or developing programs that can help older adults in the County stay out of nursing homes or provide nursing home residents access to services they may not get in their facilities.
- By advocating at the state level for critical changes that will improve the quality of care in nursing homes in the County and improve the County's ability to access and communicate with nursing home residents.

OLO has five recommendations for Council Consideration:

1. Request that the County Executive assess what support services are available to older adults in the County, particularly to older adults in nursing homes, to identify and evaluate gaps in services;

2. Ask the County Executive to identify programming and needed funding that will address gaps in services for BIPOC older adults and nursing home residents that will lead to more equitable outcomes. Ask the County Executive to report on this work to the Council on a regular basis;

3. Develop more affordable housing in the County for lower to middle income older adults on fixed incomes;

4. Work with the County Executive to address staff shortages in the County's nursing home workforce by strengthening County services and advocating at the state level; and

5. Work with the County Executive, County departments and the County's State Delegation to increase transparency into nursing homes in the County.

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Nursing Homes in the County: Regulatory Framework and Issues Impacting the Quality of Care

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Introduction

Nursing homes serve two important niches in long-term care – they provide residents access to full-time healthcare and a home. Almost 1.3 million residents live in over 15,000 Medicare-certified nursing homes in the United States. Although long-term care can be provided through other types of services, such as home healthcare, nursing homes often serve individuals who have complex care needs or who lack the resources to be cared for at home.[1]

The COVID-19 pandemic had an enormous toll on nursing home residents and staff. Two years after the pandemic began in early 2020, there were more than 200,000 reported COVID-related deaths of long-term care facility[2] residents and staff, which accounted for 23% of all COVID deaths nationally.[3] In Montgomery County, a little over a year after the start of the pandemic, nursing homes in the County reported a 15.9% COVID case fatality rate.[4]

COVID shed light on long-standing issues that have plagued nursing homes for decades, including:

- Critical staff shortages and chronic understaffing, due in part to low salaries, lack of benefits, and stressful work environments;[5]
- Cost cutting strategies such as overcrowding, which have contributed to widespread and persistent infection control deficiencies;[6] and
- Racial and ethnic disparities in the quality of care and in health outcomes.

This OLO report responds to the Council's request to examine the universe of nursing homes in Montgomery County, how state and local laws impact the operation of nursing homes in the County, and how the Council can better support nursing homes and their residents.

[1] "The National Imperative to Improve Nursing Home Quality", National Academies of Sciences, Engineering, and Medicine (2022).
[2] This count includes nursing homes, assisted living, and group homes.
[3] "Over 200,000 Residents and Staff in Long-Term Care Facilities Have Died from COVID-19", KFF (2022).
[4] According to data from August 2021, of the 4,195 confirmed COVID-19 cases in nursing homes in the County, 782 deaths were reported. From: "Nursing Home Staff Vaccination Rate in Montgomery County Highest in Maryland", MOCO360 (2021).
[5] "Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic", Government Accountability Office (2020).
[6] From January 2019 to March 2020, about 48% of all nursing homes in the country were cited with infection control deficiencies. From: "Key Questions About Nursing Home Regulation and Oversight in the Wake of COVID-19", KFF (2020).

The report is organized as follows:

- **Chapter 1. Background on Nursing Homes** describes how nursing homes operate within the broader long-term care environment and provides an overview of the reforms and regulations that shape long-term care in the United States;
- **Chapter 2. How Nursing Homes are Regulated** discusses the federal, state, and local regulatory frameworks that govern nursing homes in Montgomery County;
- **Chapter 3. Measuring Nursing Home Quality** discusses the federal and state rating systems used to measure the quality of care of nursing homes;
- **Chapter 4. Overview of Nursing Homes in Montgomery County** provides an overview of nursing homes in the County, including their location, information about their governance structure, and quality of care ratings;
- **Chapter 5. Agencies and Departments that Support Nursing Homes and Nursing Home Residents in the County** describes the agencies and departments that support nursing homes and nursing home residents in Montgomery County, and where appropriate, outlines County spending on these programs;
- **Chapter 6. Issues Impacting Nursing Homes** discusses five major issues that significantly impact the quality of care provided in nursing homes in the County and nationwide;
- **Chapter 7** presents OLO's **Findings**; and
- **Chapter 8** outlines five **Recommendations** for the Council's consideration.

Methodology. To complete this report, OLO gathered information through document reviews and a literature review of nursing homes. OLO reviewed information on regulatory histories, measurement of quality of care, issues surrounding quality of care, and racial and ethnic disparities in nursing homes. OLO also conducted stakeholder interviews with state and local agencies involved in long-term care and with nonprofit and professional associations in the long-term care sphere.

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County Government

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Dr. James Bridgers, Director
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Dr. Odile Brunetto
Bill Clark
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Patrice McGhee
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Arlee Wallace

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Eileen Bennet
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Peggy Guzman
Tenesha Moore
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Shalini Aurora

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Alexandra Baldi

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Joseph DeMattos, President
Hope Morris

Leading Age Maryland
Allison Ciborowski, CEO

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Kevin Heffner, President
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Chapter 1. Background on Nursing Homes

Individuals who require assistance with their activities of daily living, including occasional or daily supervision, short- or long-term nursing or medical care, and/or general support services, live in a variety of different housing types based on their specific circumstances and levels of need. This OLO report concerns nursing homes, which the State of Maryland defines[7] as a comprehensive care facility or extended care facility that offers nonacute inpatient care to residents who:

- Have a disease, chronic illness, condition, disability of advanced age, or terminal disease requiring maximal nursing care without continuous hospital services and;
- Require medical services and nursing services rendered by or under the supervision of a licensed nurse together with convalescent, restorative, or rehabilitative services.

While nursing homes are often referred to as skilled nursing facilities (SNFs), SNFs typically offer short-term rehabilitation services rather than extended or permanent care like nursing homes. This report excludes facilities that offer only short-term rehabilitation services from its definition of nursing homes, but it does include County facilities that offer joint short- and long-term care services.

This chapter provides context for understanding nursing homes and how they operate within the broader long-term care environment, and is organized as follows:

- **Section A** presents background information on the spectrum of long-term care housing options for older Americans;
- **Section B** discusses different nursing home ownership models and research on how ownership impacts resident care; and
- **Section C** provides a historical overview of the reforms and regulations that shaped long-term care in the United States and have influenced how nursing homes operate today.

A. Long-term Care Housing Options

Nursing homes provide a critical service to individuals who require long-term institutional care, but they are not the only housing option available to people seeking assistance with daily living. To provide context for how nursing homes fit within the larger long-term care ecosystem, this section describes different types of housing that offer varying levels of care to residents.

Assisted Living: Assisted living facilities provide housing, meals, personalized assistance, and supportive services to individuals who need help with activities of daily living, or ADLs, but who do not

[7] 10.07.02.01, Code of Maryland Regulations (COMAR).

need daily nursing services.[8] The Centers for Medicare and Medicaid Services (CMS) defined ADLs as activities related to personal care, such as bathing or showering, dressing, getting in and out of a bed or chair, walking, using the toilet, and eating.[9] Assisted living facilities in Maryland are licensed based on the level of care they provide to residents.[10]

Continuing Care Retirement Community (CCRC): CCRCs are designed to allow residents to age in place by locating independent living units, assisted living care, and skilled nursing care all in one place. CCRCs are typically the most expensive retirement option for residents, who often sign a contract for lifetime care.[11]

Group Homes: A group home is a smaller scale option for residents needing a similar level of care as in an assisted living facility, but do not want to move into a large center. Group homes in Maryland are for three to 16 unrelated individuals and must be licensed as assisted living facilities.[12]

Home and Community-Based Long-Term Care Services: For many years, Medicaid only paid for long-term care provided in an institution and not for at-home care for patients who wanted to stay in their own homes. This is now changing through State Medicaid Waiver Programs. These programs allow individuals who would qualify for nursing home care under Medicaid to receive those services in their homes. Programs in Maryland include:[13]

- **Community First Choice (CFC):** Established under the Affordable Care Act, CFC provides in-home care for individuals who are financially eligible for Medicaid and meet the level required to qualify for services in an institution.
- **Community Personal Assistance Services (CPAS):** CPAS is for individuals needing a lower level of care than required for living in an institution, but individuals must meet the same financial requirements as for the CFC program.
- **Home and Community-Based Options Waiver (HCBO):** To qualify for the HCBO program, individuals must be 18 years or older and meet the level required to qualify for services in an institution. Eligible participants must meet specified monthly income and asset limits, but do not need to qualify for Medicaid.

Nursing Homes: Nursing homes provide residents with 24-hour nursing care, supervision, and assistance, and are appropriate for individuals whose care requirements cannot be safely or adequately provided at home. Nursing homes are licensed by the Maryland Department of Health as nursing facilities or long-term comprehensive care facilities and must employ registered nurses.

[8] "Meeting the Housing Needs of Older Adults in Montgomery County", Montgomery Planning M-NCPPC (2018).
[9] "Activities of Daily Living", Centers for Medicare and Medicaid Services (2008).
[10] "Assisted Living in Maryland: What You Need to Know", Maryland Department of Aging (2002).
[11] "Meeting the Housing Needs of Older Adults in Montgomery County."
[12] Ibid.
[13] "Assisted Living in Maryland: What You Need to Know."

B. Ownership Types

Most nursing homes in the United States – over 70% – are owned by for-profit companies. Nearly a quarter are owned by non-profits, and just six percent are government owned. Today, close to 60% of nursing homes are part of corporate-owned chains, where one parent company owns two or more facilities. Research suggests that large national nursing home chains are increasingly being supplanted by smaller, regional, private equity-owned facilities.[14] (See Chapter 6 for a discussion on private equity and nursing homes). The following table presents the distribution of certified nursing facilities in the United States by ownership type.

Table 1-1. Percent of Nursing Homes in the United States by Ownership Type

Ownership Type	Percent of Nursing Homes
For-profit	**71%**
For-profit - Corporation	45%
For-profit - LLC	17%
For-profit - Individual	5%
For-profit - Partnership	4%
Non-profit	**23%**
Non-profit – Corporation	18%
Non-profit – Church related	2%
Non-profit – Other	2%
Government	**6%**
Government – County	2%
Government – Hospital district	2%
Government – State	1%
Government – City	0.5%
Government – City/County	0.5%
Government – Federal	0.1%

Note: Data are as of November 2022; data may not sum to totals due to rounding
Source: OLO analysis of CMS provider data

Researchers have found that for-profit nursing homes, and in particular private equity (PE)-owned for-profit facilities, provide lower quality of care than non-profit facilities when measured across variables such as staff-to-resident ratios, the use of physical restraints on patients, residents with pressure ulcers, and deficiencies cited by regulators.[15] Research also suggests that PE-owned nursing homes are associated with higher Medicare costs, and thus receive more tax-payer dollars despite having poorer

[14] "The National Imperative to Improve Nursing Home Quality"
[15] "Quality of Care in For-Profit and Not-for-Profit Nursing Homes: Systematic Review and Meta-Analysis,"Comondore, V., et. al., BMJ (2009).

resident outcomes than non-profit or public nursing homes.[16] (See Chapter 6 for a discussion on nursing home financing)

The growth of PE ownership in the nursing home space is attracting the attention of policy makers concerned that PE facilities are misusing public funds and placing profits over resident well-being. In 2022, the Biden-Harris Administration took steps to increase transparency around the issue by making ownership information for all Medicare-certified nursing homes available publicly for the first time ever, including data on mergers, acquisitions, consolidations, and changes of ownership.[17] While the release of this data could allow for more visibility into poorly performing nursing homes under common ownership, ownership data reported to CMS are often incomplete and do not always reflect the complex corporate structures of PE firms (i.e., parent organizations, legal entities, etc.).

C. History of Long-Term Care in the United States

This section presents a timeline of long-term care in the United States since 1935, when the enactment of the Social Security Act (SSA) ushered in an era of institutionalized care for older and disabled Americans and created the private nursing home industry. It highlights important legislative milestones which, over the last eight decades, have shaped how long-term care is offered, paid for, and regulated. This historical perspective shows how time and again, policy and lawmakers have tried to improve nursing home quality by increasing standards and reporting guidelines without placing similar attention to strengthening oversight and enforcement.

1. The Creation of the Nursing Home Industry (1935-1974)

- **1935:** the United States enacted the **Social Security Act (SSA)**. The Act established the **Old Age Assistance (OAA)** program that provided states with federal money to help poor older Americans but prohibited OAA funds from going to individuals living in public institutions (i.e., poorhouses). This led to the creation of the private nursing home industry.[18]
- **1950:** SSA amendments required that medical care payments go directly to nursing homes rather than to the beneficiaries of care and required states to license nursing homes in order to participate in OAA. Federal legislation spurred the construction of new skilled nursing facilities, increased the level of OAA payments, and created new nursing home financial assistance programs. The increase in federal spending led to greater attention on the poor quality of care in nursing homes. A federal program began working with the states

[16] "Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents,"Braun, R., et. al, Jama Health Forum (2021). ; "The National Imperative to Improve Nursing Home Quality."
[17] "Biden-Harris Administration Makes More Medicare Nursing Home Ownership Data Publicly Available, Improving Identification of Multiple Facilities Under Common Ownership," U.S. Department of Health and Human Services (2022).
[18] "Long Term Care in the United States: A Timeline," KFF (2015).; "Improving the Quality of Care in Nursing Homes", Institute of Medicine Committee on Nursing Home Regulation (1986).

and nursing home industry to develop federal guidelines for nursing home licensure programs.[19]

- **1965:** the **Medicare** and **Medicaid** programs were enacted, and the **U.S. Department of Health, Education, and Welfare (HEW)** was authorized to set standards for nursing homes who chose to participate. Medicare only covered acute care in nursing homes (e.g., post-hospital convalescence) and did not pay for long-term care. Medicaid covered long-term services provided in institutions but not in the home. This distinction created a bias in the country toward receiving long-term care in institutions. The federal and state governments became the largest payers for long-term care, prompting a dramatic rise in nursing home utilization. **The Older Americans Act (OAA)** was enacted, establishing the **Administration on Aging** within HEW.[20]
- **1967-1974:** Many nursing homes continued to be certified and operate despite being in violation of federal standards, placing pressure on legislators to strengthen enforcement. In 1970, a Senate Finance Committee staff study of Medicare and Medicaid found reliance on state certification and enforcement led to widespread noncompliance of federal standards among nursing homes. President Nixon's comprehensive welfare reform bill passed in 1972, which redefined Medicare and Medicaid skilled facilities as "skilled nursing facilities" (SNFs) and tasked HEW with creating one set of standards for Medicare and Medicaid SNFs.[21]
- **1974:** Regulations for SNFs were put into place requiring facilities to comply with standards (e.g., staffing levels, staff qualifications, fire safety, and service delivery) in order to participate in Medicare and Medicaid. Despite this, many SNFs continued to fail to meet federal standards.[22]

2. The Rise of Community-Based Services (1974-2006)

- **1974-1975:** Amendments to the Social Security Act (SSA) gave states grant money to provide social service programs (e.g., health support, transportation, adult day care, nutrition assistance, etc.) to older Americans. They also required states to prevent or reduce unnecessary institutionalization by supporting home and community-based services (HCBS).[23]
- **1978**: The Older Americans Act was amended to require that all states create **long-term care (LTC) ombudsman programs**. LTC Ombudsmen serve as advocates for nursing home

[19] "Long Term Care in the United States: A Timeline"; "Improving the Quality of Care in Nursing Homes."
[20] Ibid.
[21] Ibid.
[22] Ibid.
[23] "Long Term Care in the United States: A Timeline."

residents. They work directly with residents, service providers, and regulators to resolve issues with residents' care and quality of life.[24]

- **1981:** The HCBS waiver program was created as part of the SSA, which allowed states to cover non-medical home and community-based services through Medicaid. The waiver programs were coordinated through the State Area Agencies on Aging.
- **1987-1989: The Nursing Home Reform Act** passed under budget reconciliation (OBRA-87), strengthening quality standards at the federal and state level for nursing homes that were certified to receive Medicare and Medicaid. **The Centers for Medicare and Medicaid Services (CMS)** established the federal guidelines, and the states enforced them through licensure and inspections. Congress established the Pepper Commission to recommend legislative action on health and long-term care.[25]
- **1990-1993:** Recommendations from the Pepper Commission on financing options for long-term services and supports (LTSS) were not implemented. The Clinton Administration also failed to pass the Clinton Health Plan, which would have expanded HCBS, extended Medicaid coverage, and improved private insurance for LTC.[26]
- **1999-2006:** New and amended legislation and the Supreme Court decision that held that public entities must reasonably accommodate persons with disabilities through community-based services, led to broader HCBS coverage for individuals and gave states more money to support and expand HCBS.[27]

3. Healthcare Reform and Focus on Nursing Home Quality (2008-Present)

- **2008:** CMS implemented its **"Five-Star Quality Rating System"** to give consumers a more user-friendly rating system based on quality scores for all Medicare and Medicaid certified nursing homes.
- **2010:** Comprehensive healthcare reform passed through the **Affordable Care Act (ACA)**, which included additional nursing home reforms through the **Nursing Home Transparency and Improvement Act**, the **Elder Justice Act**, and the **Patient Safety and Abuse Prevention Act.** Under the ACA, new Medicaid programs like the Community First Choice state plan option incentivized states to improve their LTC infrastructures and expand HCBS.[28]
- **2015:** In response to concerns about the accuracy of ratings, CMS revised its Five-Star Quality rating system for nursing homes.

[24] "Long Term Care in the United States: A Timeline"; "Maryland Long Term Care Ombudsman Program," Maryland Department of Aging, Accessed Feb. 12, 2023.
[25] "Long Term Care in the United States: A Timeline."
[26] Ibid.
[27] Ibid.
[28] Ibid.

- **2016-2022:** Citing the need to improve patient safety and to reflect the significant advances made in LTC service delivery, CMS updated the requirements that LTC facilities must meet to participate in the Medicare and Medicaid programs to include infection control, emergency preparedness, revised resident rights, person-centered care, and reporting of abuse and neglect. The regulations were slated to be implemented in three phases between 2016 and 2019, but CMS did not release phase 2 and phase 3 guidance to state surveyors until 2022 due to the coronavirus pandemic.[29]

[29] "CMS Acts to Implement Revised Nursing Home Standards of Care", Center for Medicare Advocacy (2022).

Chapter 2. How Nursing Homes are Regulated

The County has little oversight and enforcement authority over nursing homes. Federal and state regulations comprise the bulk of the regulatory framework for comprehensive care facilities, with enforcement and oversight responsibilities generally split between federal and state agencies. This chapter discusses the regulatory and oversight framework at the federal, state, and County levels to illustrate how these mechanisms impact nursing home operations in Montgomery County.

- **Section A** presents the federal legal framework that governs nursing homes, nursing home residents, and families, including steps taken by the Biden Administration to improve nursing home quality;
- **Section B** discusses state laws and regulations pertaining to Maryland nursing homes, including recent changes that affect the inspection of nursing homes in Montgomery County; and
- **Section C** details County regulations and zoning ordinances that pertain to nursing homes.

A. Federal Legal Framework

This section discusses the federal laws and regulations that currently govern both nursing home operations and quality of care, as well as new rules being implemented to further improve nursing home quality.

1. The Nursing Home Reform Act of 1987

The major federal law that governs nursing homes in the U.S. today is the Nursing Home Reform Act of 1987. The law amends the 1965 Medicare and Medicaid Act which established federal criteria to certify nursing home facilities.

The Nursing Home Reform Act strengthens federal standards and establishes quality-of-life rights for nursing home residents. The law establishes the following:

- Nursing home residents' freedom from abuse, mistreatment, and neglect;
- The ability for residents to voice grievances without fear of discrimination or reprisal;
- Stricter requirements for the use of physical restraints, such as limiting the time residents can be restrained;
- Staffing requirements, such as requiring all nursing home facilities to have a registered nurse as the director of nursing and licensed practical nurses on duty, 24 hours a day, 7 days a week;
- A minimum requirement of 75 hours of training for certified nursing assistants, in addition to the requirement of passing a competency test;
- The establishment of an enforcement system for noncompliant nursing homes, which includes a requirement for states to conduct unannounced surveys at least once every 15 months; and

- The merging of Medicare and Medicaid standards and certification processes for nursing homes into a single system, and raising the standards needed for certification.[30]

2. The 2010 Affordable Care Act

After the Nursing Home Reform Act of 1987, there was no major piece of legislation regarding nursing homes until 2010. The 2010 Affordable Care Act put forth additional reforms for nursing homes that focused on transparency and resident protections, including:

- **Nursing Home Transparency and Improvement Act:** This Act requires nursing homes to report information on each member of their governing body, persons, or entities who are officers, directors, members, partners, trustees or managing employees, and other disclosable parties, along with the organizational structure of each disclosable party and relationship of each disclosable party to each other. This was meant to make nursing home information on ownership, management, and financing more accessible to the public and policymakers.[31]
- **Elder Justice Act:** This act was the first comprehensive legislation at the federal level to address the abuse, neglect, and exploitation of older adults. It provides additional protections for residents of long-term care facilities, such as nursing homes.[32]
- **Patient Safety and Abuse Prevention Act:** The purpose of this act was to prevent people with criminal backgrounds from working in nursing homes and other long-term care facilities. It required a comprehensive national system of criminal background checks, which included background checks for a history of abuse or a violence-related criminal record, as well as a check of neglect and abuse registries.[33]

3. Medicare and Medicaid Certification

As noted above, the Nursing Home Reform Act of 1987 establishes federal requirements that nursing homes must meet to participate in Medicare and Medicaid programs. Since Medicare and Medicaid are the principal purchasers of long-term care in this country, most nursing homes are Medicare- or Medicaid-certified. Therefore, the requirements for participation in Medicare and Medicaid serve as the primary form of regulation for nursing homes.[34]

In 2016, the Obama Administration issued revised nursing home regulations that included new requirements such as infection control, emergency preparedness, revised provisions to resident rights, a greater emphasis on person-centered care, and reporting of abuse and neglect. A new section on

[30] Omnibus Budget Reconciliation Act of 1987. H.R. 3545. 100th Congress (1987-1988).
[31] Patient Protection and Affordable Care Act of 2010. H.R. 3590. 111th Congress (2009-2010).
[32] "The Elder Justice Act", Administration for Community Living, Accessed Feb. 12, 2023.
[33] Patient Safety and Abuse Prevention Act. S. 1577. 110th Congress (2007-2008).
[34] "The National Imperative to Improve Nursing Home Quality", National Academies of Sciences, Engineering, and Medicine, 2022.

behavioral health services was added, in addition to new staff training program requirements and new requirements for facility quality assurance and performance improvement programs for struggling nursing home facilities.[35] Enforcement of these regulations is ultimately in the hands of federal authorities at the Centers for Medicare and Medicaid Services (CMS), but states help determine compliance by conducting facility surveys and inspections (described in section B of this chapter) and by reporting their findings and recommendations to CMS.

4. Steps to Improve Quality of Nursing Homes by the Biden-Harris Administration

Spurred by the COVID-19 Pandemic, President Biden announced new actions to improve nursing home quality during the State of the Union Address on March 1, 2022, and through a statement released on October 21, 2022. The actions address a wide range of issues, including more aggressive enforcement for the worst-performing nursing homes, more resources to support good-paying, union jobs in the nursing care industry, establishing a new minimum staffing requirement, and preventing abuse and Medicare fraud by nursing home owners. Select actions that are especially relevant to this report are described in more detail below.

- **Improving Quality of Care.** The Biden-Harris Administration announced a few different actions to improve quality of care in nursing homes. One is establishing a new federal minimum staffing requirement. There will also be more aggressive enforcement for the worst performing nursing homes. The reforms include increased financial penalties for nursing homes that fail to improve, increased requirements for safety standards for the worst performing nursing homes and increased technical assistance to help the worst performing nursing homes improve their quality of care.[36]

- **Enhancing Accountability and Oversight.** One of CMS's major tools for oversight and accountability is health and safety inspections. However, funding to conduct these inspections has remained flat over the past seven years and inspections have fallen behind in many states, including Maryland. On March 1, 2022, President Biden called on Congress to provide almost $500 million to CMS (nearly a 25% increase) to support health and safety inspections for nursing homes.[37]

- **Increasing transparency.** On February 28, 2022, President Biden called for CMS to create a new database that will track and identify owners and operators across states so that previous violations by these entities will be visible.[38] Since then, CMS has released datasets with detailed

[35] "Key Questions about Nursing Home Regulation and Oversight in the Wake of COVID-19", Musumeci, M. and Chidambaram, P., KFF (2020). ; "Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities", Federal Register (2016).
[36] "Fact Sheet: Biden-Harris Administration Announces New Steps to Improve Quality of Nursing Homes", White House Briefing Room (2022).
[37] "Fact Sheet: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes", White House Briefing Room (2022).
[38] Ibid.

information on the ownership of all nursing homes certified through Medicare, approximately 15,000 – including mergers, acquisitions, consolidations, and changes of ownership.[39] This data will aid research into the role of private equity investors in the nursing home sector.[40]

- **Improving pathways to good-paying, union jobs.** Stable and high-quality staffing is closely linked to the quality of care that nursing home residents receive. The Department of Health and Human Services (HHS) and the Department of Labor (DOL) is providing new funds to create higher-paying union jobs, and pathways to those jobs, based on recommended actions from the Biden-Harris Administration.[41] These actions include:
    - Workforce stakeholders, such as labor unions, nonprofit healthcare organizations, and industry organizations can apply for the DOL Nursing Expansion grant program which will help increase the number of nursing instructors and educators, provide career pathway training for current frontline healthcare professionals to attain credentials such as licensed practical nurses (LPN) and registered nurses (RN).[42]
    - $13 million in grants provided by HHS to expand nursing education and training to help increase the number of nursing preceptors who supervise nursing students during clinical rotations.[43]
- **Improving emergency preparedness in nursing homes.** To be better prepared for emergencies, CMS now requires each facility to have an infection control specialist, known as an infection preventionist (IP), to oversee the facility's infection prevention and control program. This differs from its previous rule that allowed off-site consultants to oversee the infection prevention program. In addition, CMS now urges providers to reduce the number of residents per room to a maximum of two residents to prevent infections.[44]

5. Resident and Family Councils

Resident and family councils play an important role in nursing home oversight by giving residents and family members a direct say in nursing homes' operations and in improving quality of care. Resident and family councils meet regularly to discuss issues of resident care, provide resources and education, and "serve as a bridge between residents and the facility."[45]

[39] "Biden-Harris Administration Makes More Medicare Nursing Home Ownership Data Publicly Available, Improving Identification of Multiple Facilities Under Common Ownership", Department of Health and Human Services (2022).
[40] "Fact Sheet: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes".
[41] "Fact Sheet: Biden-Harris Administration Announces New Steps to Improve Quality of Nursing Homes".
[42] Ibid.
[43] Ibid.
[44] "CMS Issues Significant Updates to Improve the Safety and Quality Care for Long-Term Care Residents and Calls for Reducing Room Crowding", U.S. Centers for Medicare and Medicaid Services (2022).
[45] "The National Imperative to Improve Nursing Home Quality".

The Nursing Home Reform Act of 1987 mandates resident and family councils into law, and in 2016 CMS strengthened resident and family councils' requirements through revised nursing home regulations. Nursing homes are legally required to provide councils with private meeting spaces, designate a member of staff to assist with council requests, and respond to councils' concerns and recommendations regarding resident care and quality of life.[46] Out of Montgomery County's 34 nursing homes, only two nursing homes do not have either a resident or family council.[47]

Montgomery County code specifies that nursing homes are required to consider and respond in writing to any written grievance or other communication from a family council within 10 days after receiving the communication. Nursing homes must retain public files of all communications with family councils, and must allow a resident, a prospective resident, a licensing authority, or the County's Long-Term Care Ombudsman to review the files upon request. Nursing homes must also provide all new or prospective residents with a description of the family council's purpose and function and contact information for current family council members.[48]

Researchers note that evidence on the effectiveness of these councils is limited and call for more best practice research for developing and operating successful resident and family councils. While one study found that councils enhanced communication, they did little to change policy or to empower residents.[49]

B. State Legal Framework

Maryland defines a nursing home as "a comprehensive care facility or extended care facility which offers nonacute inpatient care to residents: (a) who have a disease, chronic illness, condition, disability of advanced age, or terminal disease requiring maximal nursing care without continuous hospital services; and (b) who require medical services and nursing services rendered by or under the supervision of a licensed nurse together with convalescent, restorative, or rehabilitative services."

All of Maryland's nursing homes, including those in Montgomery County, must meet the following federal and state legal and regulatory requirements:[50]

- Medicare program requirements under the Code of Federal Regulations (CFR) at Title 42, Chapter IV, Subchapter B;
- State statutory requirements for Healthcare Facilities under Title 19 of the Maryland Code, General Health Article; and

[46] Ibid.
[47] OLO reviewed data from the CMS Care Compare website to confirm this. Layhill Nursing and Rehabilitation Center and Fairland Center are the two nursing homes.
[48] County Code § 25-24A.
[49] "The National Imperative to Improve Nursing Home Quality."
[50] Correspondence from Maryland Office of Health Care Quality (Nov. 18, 2022).

- Requirements for Nursing Homes and Food Service Facilities under state regulations at COMAR 10.07.02, 10.07.09, and 10.15.03.

In the event there is a conflict between federal and state law, nursing home facilities are required to follow the more stringent of the laws.[51] This section describes state regulations related to nursing homes in more detail, including requirements that govern licensing, state surveys and inspections, facility administration and resident care, and facility staffing, including nurse qualifications and training.

1. Licensing

State regulations require any person wanting to establish or operate a nursing home in Maryland to first obtain a license from the Secretary of the Maryland Department of Health. In 2018, a new state law eliminated all fees and expiration dates for certain healthcare facility licenses, including long-term care facilities, effectively making nursing home licenses non-expiring.[52]

Applicants seeking new nursing home licenses are required to disclose the following information related to ownership of the facility:[53]

- All members of the governing body, with their business addresses;
- Ownership of real property;
- The identity of any management company that will operate or contract with the applicant to operate the facility;
- Ownership of equipment; and
- The names of persons holding 5% or greater of stocks or assets.

Applicants are also required to provide proof of their ability to operate and maintain a nursing home in compliance with state and federal standards of medical and nursing care. Specifically, applicants must provide information related to:[54]

- The past or current operation of a nursing home, other healthcare facility, assisted living program, residential service agency or other licensed in-home care service, or licensed community program for individuals with developmental disabilities, substance abuse, or mental health needs, located within or outside Maryland;
- The identities of the facility's medical director, director of nursing, and administrator, as well as the nursing home's quality assurance plan; and

[51] Ibid.
[52] Senate Bill 108, *Regulation of Health Care Programs, Medical Laboratories, Tissue Banks, and Health Care Facilities - Revisions*, Maryland General Assembly, 2018 Regular Session; Maryland State Bar Association, "Maryland Facility Licenses No Longer Expire.", Accessed Jun. 22, 2023.
[53] 10.07.02.04, Code of Maryland Regulations (COMAR).
[54] Ibid.

- The facility's financial and administrative ability to maintain a compliant nursing home, including submission of an audited financial statement, and whether the applicant ever operated a nursing home, related institution, or other healthcare facility.

The Secretary of Health may decide to approve nursing home license applications, approve applications with conditions (e.g., requiring submission of staffing schemes), or deny applications. Researchers note, however, that state regulators do not often deny or revoke nursing home licenses as it could be disruptive to residents. Most states consider denial or revocation to be an extreme penalty "that should be reserved for only serious breaches of resident safety and quality-of-care standards."[55]

The Department of Health is also required to withhold licenses from any facility found to have health and safety deficiencies until that facility submits an acceptable written plan of correction within 10 working days of receiving a notice of deficiencies.[56]

2. State Surveys and Inspections

States conduct nursing home surveys and inspections on behalf of CMS to determine their compliance with Medicare and Medicaid health and safety standards. Each state has a CMS-designated state survey agency that performs this certification process. The Office of Health Care Quality (OHCQ) in the Maryland Department of Health (MDH) is Maryland's designated state survey agency and is responsible for nursing home licensing, inspections, and certification of compliance.

OHCQ uses federal survey guidance to conduct standard onsite inspections of Medicare-or Medicaid-certified nursing homes at least once every 15 months. The agency also investigates any complaints it receives from the public and from within facilities about resident care or safety. State surveys are administered by teams of healthcare professionals and/or administrators[57] who are assigned to geographic regions within Maryland. MDH reports that "surveyors are rotated between teams to maintain objectivity and the integrity of the survey process."[58]

Deficiencies and Penalties. Nursing homes found to be in violation of a federal standard during a survey or investigation are assigned a deficiency. OHCQ then reports the scope and the severity of deficiencies to CMS and provides recommendations for enforcement.[59] CMS ultimately has the authority to penalize poorly performing facilities based on the severity of deficiencies. Often, nursing homes must submit plans of correction demonstrating how the deficient practice(s) will be corrected, and Maryland law dictates that licenses must be withheld from any facility found to have deficiencies

[55] "The National Imperative to Improve Nursing Home Quality."
[56] Ibid.
[57] Ibid.
[58] Ye, Webster Ye. Letter to Barbara Selter, Sept. 13, 2022. Maryland Department of Health.
[59] The scope of deficiencies refers to the number of residents potentially affected, and the severity of deficiencies refers to the potential for or occurrence of harm to residents; "Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic,", U.S. Government Accountability Office (2020).

until that facility submits an acceptable written plan of correction.[60] The most common sanctions imposed by CMS for noncompliance are civil monetary penalties (CMPs), or fines.[61] In the most serious cases where state surveyors find evidence of immediate jeopardy,[62] a nursing home's Medicare/Medicaid participation could be terminated, or it could face other severe penalties like a revocation of its license.

Previous History of County Surveys and Inspections. Until recently, inspections of nursing homes in Montgomery County were conducted by County surveyors. A long-standing Memorandum of Understanding (MOU) between MDH and the County allowed a team of County surveyors to conduct certifications, surveys, and complaint investigations on behalf of the state. The team consisted of eight to 10 nurses and nurse administrators employed by the Montgomery County Department of Health and Human Services (DHHS).[63]

The County surveyors would perform annual survey inspections in County nursing homes, report their findings to the state, and then receive the state's recommendations. If violations were found, state and federal regulators would step in to handle enforcement. If the state received complaints about nursing homes, that information would be relayed to the County surveyor team who would then perform the investigation.[64]

In February of 2021, the State of Maryland terminated the MOU between MDH and Montgomery County, citing that "there will be no funding for [the services provided under] the MOU after June 30, 2021." OHCQ, Maryland's designated survey agency, absorbed the work previously done by the eight to 10 County surveyors. The state also retained the funding that would have supported the County surveyor team, causing DHHS to lose those positions.[65]

Over the next year, concerns arose within DHHS and within the Montgomery County Commission on Aging (CoA)[66] that OHCQ was not properly enforcing regulations in Montgomery County nursing homes. In a letter to Maryland State Senator Benjamin Kramer dated August 1, 2022, CoA COA Chair Barbara Selter wrote:

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[60] "Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic" ; "The National Imperative to Improve Nursing Home Quality."

[61] "The National Imperative to Improve Nursing Home Quality."

[62] CMS defines "immediate jeopardy" as a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. CMS, 2018b; "The National Imperative to Improve Nursing Home Quality."

[63] Interviews with DHHS staff.

[64] Ibid.

[65] Nay, Patricia Tomsko. "Termination of Memorandum of Understanding Between Maryland Department of Health and Montgomery County, Maryland," Feb. 16, 2021. Maryland Department of Health Office of Health Care Quality.

[66] The Montgomery County Commission on Aging (CoA) advises the County Council, County Executive, DHHS, and other County departments on the needs of older adults in the County. CoA advocates at all levels of the government for laws, policies, or programs that impact older adults, develops budget and legislative priorities, and issues research reports on topics relevant to the County's older adult population.

> "It is our understanding that since July 1, 2021, there were no annual surveys of the 33[67] nursing facilities in MC [Montgomery County] and about six complaint surveys were conducted. The MC Long Term Care Ombudsman Program filed numerous complaints on behalf of nursing facility residents that have not been investigated. In addition, the MCDHHS Licensure & Regulatory Program submitted two complaints regarding infection control concerns observed by County sanitarians that also have not been investigated. In fact, we have not been able to determine how many, if any, infection control inspections were conducted in MC since July 1, 2021, when the state assumed responsibility for such inspections."[68]

In September of 2022, OHCQ responded to Chair Selter's inquiry, noting "since July 2021, OHCQ's oversight of Montgomery County nursing homes has included annual surveys, complaint investigations, life safety code surveys, resident fund surveys, and surveys for change of ownership."[69] In a subsequent email sent to Maryland State Delegate Kirill Reznik, OHCQ specified that between July 1, 2021 and September 14, 2022, its surveyors conducted 172[70] surveys at 33 nursing homes in the County, as follows:[71]

- 69 complaint surveys at 28 individual nursing homes in the County;
- 48 COVID reporting surveys at 21 individual nursing homes;
- 11 focused infection control surveys at 7 nursing homes;
- 20 follow-up surveys at 16 different nursing homes;
- 10 life safety code surveys at 6 nursing homes;
- 4 recertification surveys at 3 nursing homes;
- 2 state licensure surveys at 1 nursing home; and
- 8 other[72] surveys at 6 nursing homes.

OHCQ also reported imposing "43 state civil money penalties [CMPs] on nursing homes for noncompliance with COVID reporting requirements as well as 14 CMPs related to other federal and/or state regulations."[73] OHCQ did not specify which federal and/or state regulations had been violated, nor did it clarify whether the enforced penalties resulted from investigated complaints.[74]

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[67] There were 33 nursing homes in Montgomery County at the time this letter was written. Currently, there are 34 nursing homes in the County.

[68] Selter, Barbara. Letter to The Honorable Benjamin Kramer, Aug. 1, 2022. Montgomery County Commission on Aging, Department of Health and Human Services.

[69] Ye, Webster Ye. Letter to Barbara Selter, Sept. 13, 2022. Maryland Department of Health.

[70] County staff note that state survey teams often conduct multiple surveys and investigations during a survey visit that could last up to one month. One survey of a nursing home, therefore, can often include an annual survey, an investigation of all complaints received since the previous survey, and other surveys and audits.

[71] Correspondence from Maryland Office of Health Care Quality. (Nov. 18, 2022).

[72] Includes emergency preparedness surveys, licensure complaints, and resident fund surveys.

[73] Ye, Webster Ye. Letter to Barbara Selter, Sept. 13, 2022. Maryland Department of Health.

[74] Correspondence from Maryland Office of Health Care Quality.

3. Nursing Home Staffing Requirements

Maryland regulations require that all nursing homes provide a full-time registered nurse (RN) to serve as the facility's Director of Nursing (DON) and to oversee the home's nursing services. Regulations state that nursing homes must provide the following ratio of RNs to residents:[75]

Table 2-1. Ratio of Resident Nurses to Nursing Home Residents Required by Maryland Regulations

Number of Residents	Number of RNs*
2 – 99	1 RN full-time
100 – 199	2 RNs full-time
200 – 299	3 RNs full-time
300 – 399	4 RNs full-time

*Includes the director of nursing's time

There is no similar ratio of nursing staff to residents required by the federal government.

While the federal government does not require a minimum number of direct care nurse and nursing assistant hours per resident per day, research conducted by CMS has led the federal government to recommend a daily minimum staffing standard of 4.1 hours of total direct care nursing time per resident. Except for the District of Columbia, which has a standard of 4.16 hours per day of total nursing staff time, no state in the country has a standard as high as the federal recommended staffing standard.[76]

The table on the next page provides a comparison between federal minimum requirements and Maryland's minimum staffing requirements. As the table describes, all nursing homes in Maryland must have at least one RN on duty, 24 hours a day, 7 days a week. Furthermore, homes must employ sufficient supervisory and support personnel including RNs, licensed practical nurses (LPNs), and certified nursing assistants (CNAs) to provide each resident with a minimum of 3 hours of direct care per day, 7 days a week. The rules also state that if the DON's hours are counted toward the 3-hour minimum, those hours must be spent in direct care (as opposed to administration) and must be documented.[77] The DON is also required to ensure their nursing staff "maintain professional competence" by providing all new personnel with a comprehensive job orientation and all nursing service personnel with a continuing in-service education program. Because the federal government only has recommended standards for direct care staff, this is used in the table's comparison to Maryland's minimum requirements for direct care staff.

[75] 10.07.02.19, Code of Maryland Regulations (COMAR).

[76] "State Nursing Home Staffing Standards: Summary Report,", The National Consumer Voice for Quality Long-Term Care (2021).

[77] 10.07.02.19, Code of Maryland Regulations (COMAR).

Table 2-2. Comparison of Maryland and Federal Minimum Nursing Home Staffing Requirements

Nursing Home Staffing	MD Minimum Requirements	Federal Minimum Requirements
Licensed Staff (RN, LPN/LVN*)	1 DON RN 1 RN/LPN Charge Nurse on duty at all times 1 RN 24 hours, 7 days a week For 2-99 residents: 1 RN full-time For 100-199: 2 RNs full-time For 200-299: 3 RNs full-time For 300-399: 4 RNs full-time	1 DON RN 5 days a week (DON may also be Charge Nurse if fewer than 60 residents) 1 RN/LPN for 2 remaining shifts 1 RN 8 consecutive hours/7 days a week
Direct Care Staff	3.0 hprd** (including RNs, LPNs, supportive personnel, and only the documented hrs. of DON) No less than 1:15 ratio of nursing service personnel providing bedside care to residents at all times	**Recommended Staffing Standard:** 4.1 hprd provided by all nursing staff 0.75 from RNs; 0.55 from LPNs/LVNs; and 2.80 from CNAs/NAs
Sufficient Staff	To provide bedside care	Sufficient numbers of all nursing staff to meet residents' needs

*Licensed Vocational Nurse

** Hours per resident per day. This is the number of hours of care provided to each resident each day by nursing staff (RNs, LPNs/LVNs, CNAs/NAs). It is determined by dividing the total number of nursing staff hours worked by the total number of residents.

Source: "State Nursing Home Staffing Standards Summary Report," The National Consumer Voice for Quality Long-Term Care (2021).

Nurse Training and Certification. The Maryland Board of Nursing certifies all nursing assistants in the state. In addition to the basic CNA certification, all nursing assistants who work in licensed comprehensive care facilities (i.e., nursing homes) must also pass the state's Geriatric Nursing Assistant (GNA) examination. In conversations with OLO, nursing home industry stakeholders noted that this additional requirement discourages many CNAs from entering the nursing home workforce in Maryland and is not known to be required in any other state.[78]

[78] See Chapter 6 for more information on the GNA certification process.

4. Resident Rights

State regulations also provide Maryland nursing home residents with basic rights to help ensure they receive the quality of care and quality of life they need. A list of core rights is summarized below.[79] The full text of Maryland's nursing home resident rights is included in Attachment 1.

- Residents have the right to receive appropriate care that is focused on their quality of life and to voice grievances about the care they receive;
- Residents have the right to access and communicate with people and services outside of the facility, including government representatives like State LTC Ombudsmen;
- Residents have the right to be free from abuse, discrimination, and exploitation;
- Residents have the right to be informed of and to participate in decisions regarding their care, diagnosis, treatment, and prognosis, as well to have access to their medical records; and
- Residents have the right to organize and participate in resident and family groups.

5. Steps to Improve Nursing Home Quality at State Level

Maryland Governor Wes Moore has expressed support for older adult residents' ability to age comfortably and with dignity. Some of the specific actions Moore pledged to work on as governor that could impact long-term care in Maryland include:

- Improve state and local service delivery for Maryland's older adults by filling vacancies and increasing staffing levels at Maryland's Department of Aging (MDOA) and educating the public about the services offered by MDOA;
- Improve access to affordable housing and support older adults' ability to safely age-in-place by funding additional slots and reducing wait times for the Community Options Waiver program, which would give older adults access to home-based care, expand access to funding for accessible home modifications, and secure financial support to family caregivers;
- Improve existing long-term care facilities by leveraging federal dollars to ensure better oversight and compliance, addressing staffing shortages and fighting for better wages for nursing home staff; and
- Combat elder abuse, exploitation, and fraud by partnering with community organizations to increase training for older Marylanders about their rights, as well as home healthcare workers, law enforcement officers and family members so they can more easily recognize and report these incidents.

In April 2022, the Maryland General Assembly created the Commission to Study the Health Care Workforce Crisis in Maryland. The commission's charge is to determine the extent of the health care workforce shortage in Maryland, including in nursing homes, and examine gaps in healthcare. The

[79] 10.07.09.08, Code of Maryland Regulations (COMAR).

commission will examine turnover rates and the average length of employees' tenure, and it will consider strategies for recruiting and retaining healthcare workers, including changes to high school curricula, mid-career transition programs, enhanced benefits for employees, grant programs and tuition subsidies.[80] The commission's final report is due by December 31, 2023.

In the last few years, multiple bills introduced in the Maryland General Assembly have specifically targeted the nursing home industry. The following is a list of legislation introduced, and when applicable, the effect date of enacted legislation.

- **Senate Bill 468, Funding for Wage Increases for Medical Provider Workers[81]** – Proposes that each nursing home must submit a cost report that includes documentation of wage disbursement as well as any other information the Department of Health determines is appropriate. The bill further requires that 90% of the funding increase provided by state appropriations for FY24 must be used to fund wage increases for staff working in a nursing home who provide direct care to residents and support staff in a nursing home, including housekeeping, laundry, nutritional, and activity services.[82] The bill took effect on June 1, 2023.[83]
- **Senate Bill 604, Maryland Medical Assistance Program – Provider Agencies and Personal Care Aides – Reimbursement and Wages[84]** – Proposes a requirement that the Maryland Department of Health and other provider agencies increase the hourly reimbursement rate for certain personal assistance services (including Home and Community Based Services) under the Maryland Medical Assistance Program, with an additional requirement of provider agencies submitting annual cost reports to the Department of Health.[85]
- **Senate Bill 677, Maryland Health Care Commission (MHCC)– Nursing Homes – Reporting** – Proposes requiring MHCC to post on its website: (1) a report for each nursing home that contains each change in ownership at a licensed nursing home; (2) information on the trends in the utilization of licensed nursing homes in the state; and (3) a summary of the financial data regarding licensed nursing homes. It also requires MHCC to publish searchable information on licensed nursing homes and links to nursing homes' cost reports on their website.[86]
- **Senate Bill 509, Health Care Facilities – Nursing Homes – Acquisitions and Licensure[87]** – Proposes requiring MHCC to provide certain information regarding the acquisition of a nursing

[80] "Commission to Study the Health Care Workforce Crisis in Maryland", Maryland Manual On-line, Accessed Feb. 15, 2023.
[81] Senate Bill 468 is cross-filed with House Bill 725, which means they are identical bills introduced in both chambers.
[82] Funding for Wage Increases for Medical Provider Workers, Senate Bill 468, Introduced in the General Assembly of Maryland on February 3, 2023.
[83] Funding for Wage Increases for Medical Provider Workers Fiscal and Policy Note, Senate Bill 468 (2023).
[84] Cross-filed with House Bill 318
[85] Maryland Medical Assistance Program - Provider Agencies and Personal Care Aides - Reimbursement and Wages, Senate Bill 604, Introduced in the General Assembly of Maryland on February 6, 2023.
[86] Maryland Health Care Commission - Nursing Homes - Reporting, Senate Bill 677, Introduced in the General Assembly of Maryland on February 4, 2022.
[87] Cross-filed with House Bill 702

home to the Office of Health Care Quality (OHCQ) including the quality ratings of facilities currently or previously owned by the purchaser of the healthcare facility in addition to requiring the Secretary of Health to consider the information before taking action regarding licensure to operate a nursing home.[88] By December 1, 2023, MHCC, must complete a study regarding the expansion of the Certificate of Need (CON) program over the acquisition of nursing homes. The bill's provisions relating to this required study took effect on July 1, 2023.[89]

- **Senate Bill 137, Income Tax – Credit for Long-Term Care Premiums[90]** - Proposes the alteration of eligibility for and the maximum amount of a credit against the state income tax for certain long-term care insurance premiums.[91] The bill took effect on July 1, 2023 and applies to the 2023 tax year and beyond.[92]

C. Local Legal Framework

This section details County regulations and zoning ordinances that pertain to nursing homes. Many of the regulations in the County Code are drawn from federal and state regulations for nursing homes.

In the Montgomery County Code, *Chapter 25 Hospitals, Sanitariums, Nursing and Care Homes* is the main regulatory chapter for nursing homes.[93] The director of the Department of Health and Human Services is charged with administering and enforcing the provisions of Chapter 25.[94] Section 3.3.2 in the uses and use standards of County Ordinances describes land use and zoning laws associated with County nursing homes.[95],[96]

The County Code defines nursing homes as "an institution which maintains conditions or facilities and equipment for provision of nursing care for chronically ill or convalescent patients. This shall include convalescent homes, nursing units of homes for the aged, psychiatric nursing homes, nursing facilities

[88] Health Care Facilities - Nursing Homes - Acquisitions and Licensure, Senate Bill 509, Introduced in the General Assembly of Maryland on February 3, 2023.
[89] Health Care Facilities - Nursing Homes - Acquisitions and Licensure Fiscal and Policy Note, Senate Bill 509 (2023).
[90] Cross Filed with House Bill 160
[91] Income Tax - Credit for Long-Term Care Premiums (Long-Term Care Relief Act of 2023), Senate Bill 137, Introduced in the General Assembly of Maryland on January 13, 2023.
[92] Income Tax - Credit for Long-Term Care Premiums Fiscal and Policy Note, Senate Bill 137 (2023).
[93] Montgomery County Code (MCC) §25-1. Accessed Jan. 18, 2023.
[94] Ibid.
[95] Montgomery County Code (MCC) §59-3, Accessed Jan. 18, 2023.
[96] Staff note that current zoning regulations have not been incorporated into Chapter 25 of the County Code. Chapter 25 County regulations and zoning ordinances are from 1965 and are not applicable now. Staff recommend that the Code should be updated to reflect new zoning regulations.

for the handicapped[97], homes for alcoholics, halfway houses, or any other home type facility which admits patients and holds itself out as providing 24 hours per day nursing care for such patients."[98] Chapter 25 of the County Code covers many requirements that County nursing homes must adhere to such as:

- Which County officials have right of entry;
- Posting of inspection reports;
- Authority of the Council sitting as the Board of Health to adopt and enforce needed standards and regulations of nursing homes and other health institutions;
- Licensure compliance and fees;
- Health standards and regulations; and
- Building and fire regulations.

Selected regulations pertaining to nursing homes are summarized and discussed in more detail below.

1. Right of Entry of County Officials

The director of DHHS, the fire marshal, the superintendent of police and "such subordinate officials as may be expressly designated by the above-named county officials" have the right to enter the premises of nursing home facilities for the purpose of inspecting all spaces and areas, except for any living quarters of staff members without the consent of the occupant, at any time that may be necessary for the health, safety, or welfare of the patients.[99]

2. Rules and Regulations of Board of Health

The Montgomery County Council sits as the County Board of Health. This gives the Council the authority to adopt and enforce any needed standards and regulations for the health, safety, welfare, and physical requirements of the patients in institutions. However, any adopted rules and regulations must not conflict with any rules and regulations that the Maryland State Board of Health puts forth.[100]

3. Licensing

In addition to state licensing requirements for nursing homes, nursing homes must obtain two County licenses annually: a nursing home license and a food service facility license. Staff report nursing homes use the County nursing home license to renew their facilities' insurance.[101] A facility must acquire a

[97] County staff in DHHS's Licensure and Regulatory Division note that several of the "nursing facilities for the handicapped" are not licensed by their office.
[98] Montgomery County Code (MCC) § 25-3, Accessed Jan. 18, 2023.
[99] Ibid.
[100] Ibid.
[101] Feedback from County staff.

permit stating that the building(s) complies with both state and local fire codes and regulations before the director of DHHS will issue the license for County nursing homes.[102]

DHHS requires the following items before a nursing facility's license is renewed:[103]

- A completed application;
- Payment of fees per bed;
- A fire permit from the local jurisdiction; and
- A copy of the state license.

Further, during the issuing or renewal of a license, the DHHS director has the authority to investigate the applicant, licensee, owner, operator, person in charge, or all employees who have supervisory duties tangential to the care of patients upon their "good moral, reputable and responsible character" which includes the following areas of analysis:

- All police and penal history;
- Licensing history and history of person(s)' operation of similar institutions; and
- General personal history.[104]

OLO notes that if the County did not issue a County license to a nursing home, the nursing home could still operate if it had a valid state license.[105]

4. Applicable Zoning Ordinances

In the zoning ordinances, nursing homes fall under the category of "Residential Care Facility." Other facilities that fall under this category include assisted living facilities, Continuing Care Retirement Communities, hospices, group homes, and Senior Care Communities. The zoning ordinance established standards that nursing homes must follow related to things such as building height, density, age requirements for residents, and green space.

[102] Montgomery County Code (MCC) §25-1. Accessed Jan. 18, 2023.; Feedback from County staff.
[103] Feedback from County staff.
[104] Montgomery County Code (MCC) §25-3, Accessed Jan. 18, 2023.
[105] Feedback from County Staff.

Chapter 3. Measuring Nursing Home Quality: Federal and State Ratings

Ratings of the quality of care in nursing homes are available publicly and are meant to be presented in a consumer-friendly way. This chapter discusses how the quality of care of nursing homes are measured at the federal and state level.

- **Section A** provides an overview of the federal and state agencies responsible for rating the quality of care of nursing homes;
- **Section B** discusses the federal rating system, including critiques of the current system; and
- **Section C** discusses Maryland's rating system.

A. Overview of Federal and State Ratings Agencies

The **Centers for Medicare & Medicaid Services (CMS)** is a federal agency within the U.S. Department of Health and Human Services (HHS). CMS is responsible for ensuring that nursing homes meet federal quality standards to participate in Medicare and Medicaid programs. While CMS was established in 1965, it began publishing public ratings for nursing homes in 1998. The current five-star rating system was rolled out in 2008.[106]

Scores are based on a five-star system, with one star being the lowest score and five stars being the highest. To obtain these scores, CMS partners with relevant state agencies to conduct surveys about once a year, in addition to obtaining self-reported data from nursing home facilities, residents, and residents' families.[107] CMS also authorizes state agencies to investigate complaints from the public as well as facility-reported incidents regarding resident care and/or safety.[108] The Office of Health Care Quality (OHCQ) is the authorized Maryland agency for conducting surveys and investigating complaints.

At the state level, the **Maryland Health Care Commission (MHCC)** is an independent regulatory agency, separate from OHCQ, that reports quality of care data for consumers on the healthcare system, including nursing homes.[109] MHCC publishes data publicly on their Maryland Quality Reporting website.[110] Data included on the website includes quality ratings data from CMS, as well as private pay and Medicare daily rates. There is also an annual statewide survey called the Nursing Home Family Experience of Care Survey sent out to families of residents to obtain their satisfaction rates with their

[106] "Five Star Changes to Nursing Home Compare", Centers for Medicare and Medicaid Services (2016).
[107] "Five-Star Quality Rating System", Centers for Medicare and Medicaid Services, Accessed Feb. 14, 2023.
[108] "Infection Control Deficiencies were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic", U.S. Government Accountability Office (2020).
[109] Maryland Quality Reporting "About Us", Maryland Health Care Commission, Accessed Feb. 23, 2023.
[110] Ibid.

nursing home, which MHCC conducts and reports data on.[111] Further, MHCC reports on all nursing homes in the state, not just nursing homes participating in Medicare and Medicaid like CMS does.

B. The Centers for Medicare and Medicaid Services (CMS) Ratings

CMS first began publishing publicly available reporting of nursing home performance in 1998 through their website *Nursing Home Compare*. The intention was to help consumers and their families make an informed decision about nursing homes, as well as to encourage nursing homes to improve their quality through the public reporting of their performance.

In 2008, CMS implemented the "Five-Star Quality Rating System" to provide a more user-friendly rating system based on quality scores for all Medicare and Medicaid certified nursing homes. In 2015, CMS modified the star rating system to address concerns about the accuracy of the ratings, which is explained in section 2 below. CMS further updated its methodology in July 2022.

1. How CMS Ratings are Calculated

The current rating system calculates an overall star rating – with one star being the lowest score and five being the highest – based on performance in three categories of measures described below. Each of these measures are given individual star ratings. Each measure is discussed in more detail later in the chapter.

1. **State Health Inspection Measures** are taken from the annual state health inspection reports, which include information on deficiencies such as: the number and severity of problems, revisits needed to document whether those deficiencies were corrected, and actions taken by nursing homes to investigate complaints. Deficiencies are weighted based on the severity such as deficiencies that cause "immediate jeopardy to resident health or safety" and considers when deficiencies are reoccurring rather than isolated incidents.
2. **Staffing Ratio Measures** are self-reported by nursing homes and includes the ratio of nurses to residents, which is measured by nurse hours per resident per day.
3. **Quality Measures** are self-reported, and the score is derived from data on the average scores of the latest four quarters.

[111] "Maryland Quality Reporting Website Data Sources", Maryland Health Care Commission (2022).

The table below describes the quality associated with each number of stars awarded.

Table 3-1. Quality Associated with CMS Star Ratings

Number of Stars	Quality Compared to Other Nursing Homes in the State
One Star	Much Below Average
Two Star	Below Average
Three Star	Average
Four Star	Above Average
Five Star	Much Above Average

The overall star ratings are a composite of the three measures described above. However, there are several algorithms that apply to the overall star rating calculation and these measures are weighted differently. This is to prevent a nursing home from receiving a high overall rating if they received a one- or two-star rating in one or more individual categories. For example, if a nursing home received only one star for its state health inspection measure, then its maximum overall star rating is capped at two stars. Further, if a nursing home receives one star in the quality measures category, the overall rating will be reduced by one star.

State Health Inspection Measures

Nursing homes must obtain an onsite recertification inspection annually to participate in Medicare and/or Medicaid programs.[112] In Maryland, the inspections are administered by the Office of Health Care Quality. Inspections are unannounced, conducted by a team of health care professionals, and generally last several days. Nursing homes are assessed on whether they comply with federal requirements and the assessments cover facility practice and policies in the following areas:[113]

- Resident Rights
- Quality of Life
- Medication Management
- Skin Care
- Resident Assessment
- Nursing Home Administration
- Environment
- Kitchen/Food Services

If OHCQ finds any health or safety violations during an inspection, the home must correct any problems within an allotted time frame based on the type of violation. OHCQ can also stop nursing

[112] "Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical User's Guide", Centers for Medicare and Medicaid Services (2023).
[113] Ibid.

homes from accepting new residents, stop Medicare payments to the nursing home, impose financial penalties, or revoke the home's license to operate until a violation is resolved.[114]

Further, health inspections are based on federal regulations and federal staff train and oversee state inspectors and performance.[115] However, there is still variation among states in both the inspection process and outcomes, as discretion is given to individual inspectors and their respective state agencies in how they assign deficiencies, impose penalties, and report nursing homes for abuse and neglect.[116] For example, a 2019 Government Accountability Office report found great variation in the ways that states report, track, and process reports of abuse in nursing homes.[117]

Staffing Measures

The staffing measures, and subsequent ratings, are based on nursing home staffing levels and staff turnover. Nursing homes self-report their staffing data to CMS, as data is derived from the Payroll-Based Journal System (PBJ) which is entered by nursing home administrators.[118] CMS conducts audits of nursing homes to verify the data submitted and to ensure accuracy.[119] There are six measures, described below:

- Three nurse staffing level measures: (1) Total nurse staffing; (2) Adjusted RN staffing; and (3) Total nurse staffing on the weekends.
- Three measures of staff turnover: (1) Total nurse turnover; (2) RN turnover; and (3) Administrator turnover.

Nursing homes submit this staffing data quarterly and CMS uses the data to calculate and post quarterly ratings on the CMS website. Overall, to receive a five-star rating in staffing, a nursing home must have staffing levels that equate to five stars for both RNs and total nurses.[120]

Quality Measures

There are 15 specific measures that illustrate the quality-of-care residents receive in the nursing home, including nine long-stay measures and six short-stay measures. Long stay residents are defined as those who are in the nursing home for 100 or more days while short stay residents are in the nursing home for less than 100 days.[121] The data comes from the Minimum Data Set (MDS), which is a

[114] "Nursing Homes: What You Need to Know", Maryland Attorney General (2019).
[115] Federal oversight includes quality checks based on a 5% sample of health inspections performed by states, where federal inspectors either accompany state inspectors or replicate the inspection within 60 days to compare results.
[116] "Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse", United States Government Accountability Office (2019).; "Key Issues in Long-Term Services and Supports Quality", Harrington, C., et. al., KFF (2017).
[117] "Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse".
[118] "Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical User's Guide".
[119] Ibid.
[120] Ibid.
[121] Ibid.

federally mandated clinical assessment of all residents in Medicare and Medicaid certified nursing homes,[122] and Medicare claims data which provides information on services provided by Medicare certified nursing homes.[123]

Measures for long-stay residents derived from MDS assessments:

- Percentage of long-stay residents whose need for help with daily activities has increased
- Percentage of long-stay residents whose ability to move independently worsened
- Percentage of long-stay high-risk residents with pressure ulcers
- Percentage of long-stay residents who have or had a catheter inserted and left in their bladder
- Percentage of long-stay residents with a urinary tract infection
- Percentage of long-stay residents experiencing one or more falls with major injury
- Percentage of long-stay residents who got an antipsychotic medication

Measures for long-Stay residents derived from claims data:

- Number of hospitalizations per 1,000 long-stay resident days
- Number of outpatient emergency department (ED) visits per 1,000 long-stay resident days

Measures for short-stay residents derived from MDS assessments:

- Percentage of short-stay residents who improved in their ability to move around on their own
- Percentage of Skilled Nursing Facility (SNF) residents with pressure ulcers/pressure injuries that are new or worsened
- Percentage of short-stay residents who got antipsychotic medication for the first time

Measures for short-stay residents derived from claims data:

- Percentage of short-stay residents who were re-hospitalized after a nursing home admission
- Percentage of short-stay residents who have had an outpatient emergency department (ED) visit
- Rate of successful return to home and community from a SNF[124]

[122] "Minimum Data Set 3.0 Public Reports", Centers for Medicare and Medicaid Services", Accessed Feb. 13, 2023.
[123] "How Do I File a Claim", U.S. Centers for Medicare and Medicaid Services, Accessed Feb. 13, 2023.
[124] "Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical User's Guide".

Trends in CMS Ratings. Overall, there are some trends in characteristics of nursing homes relative to their star ratings. The following section presents national data on nursing homes related to their CMS star rating:

- Nationally, over one-third of nursing homes that are certified by Medicare or Medicaid have overall one- or two-star ratings. 39% of all nursing home residents reside in these nursing homes.[125]
- 45% of nursing homes have overall four- or five-star ratings. 41% of all nursing home residents reside in these nursing homes.[126]
- In general, for-profit nursing homes tend to have lower star ratings compared to non-profit nursing homes.[127]
- Nursing homes with fewer beds tend to have higher star ratings than larger nursing homes with more beds.[128]
- States that have higher proportions of low-income seniors tend to have lower-rated nursing homes.[129]
- Ratings tend to be higher for measures that are self-reported (quality measures and staffing levels) than for measures taken from state health inspection data.[130]

2. Critiques of CMS Ratings

While the CMS five-star rating system can be helpful for some consumers, experts in the field have raised valid critiques about its effectiveness and validity. In general, quality measurement and reporting are imperfect, especially those that include self-reported metrics like CMS's "Five-Star Quality Rating System." Some of the critiques of the CMS ratings are summarized below by source.

U.S. Department of Health and Human Services (DHHS) Office of Inspector General (OIG). A 2021 study on the CMS use of data on Nursing Home Staffing found that:

- CMS provides the public with most – but not all – required information about staffing of nursing homes. At the time of the OIG report, CMS did not publicly post data on staffing turnover and tenure.[131] They began posting it on the Care Compare website in January 2022;[132] and

[125] "Reading the Stars: Nursing Home Quality Star Ratings, Nationally and by State", Boccuti, C., Casilla, G., and Neuman, T., KFF (2015).
[126] "Reading the Stars: Nursing Home Quality Star Ratings, Nationally and by State".
[127] Ibid.
[128] Ibid.
[129] Ibid.
[130] Ibid.
[131] "CMS Use of Data on Nursing Home Staffing: Progress and Opportunities to Do More", U.S. Department of Health and Human Services Office of Inspector General (2021).
[132] "Nursing Home Staff Turnover and Weekend Staffing Levels", Centers for Medicare and Medicaid Services, Accessed Feb. 15, 2023.

- There is no robust process for ensuring the reliability of non-nurse staffing data, such as administrative staff. CMS does have a robust process for ensuring the reliability of nurse staffing data.[133]

An earlier study published in 2019 by the DHHS OIG found that incidents of potential abuse and neglect in nursing facilities were not always reported and investigated.[134] Key findings included:

- CMS found that in 2016, about one in five high-risk hospital ER Medicare claims for residents of skilled nursing facilities (SNFs) were the result of potential abuse or neglect, such as an injury caused by unknown sources. The OIG determined that SNFs in the study failed to report many of these incidents to state survey agencies, which is required by federal law;
- Further, several state survey agencies failed to report some findings of substantiated abuse to local law enforcement;
- CMS does not require certain information about incidents of potential abuse or neglect to be recorded. This can lead to potential abuse and neglect complaints being unrecorded, and therefore not followed up on; and
- Neglecting to report all incidents of potential abuse and neglect can lead to star ratings that do not reflect the reality of the quality of care provided in nursing homes.

Health Services Research Journal. A 2019 study published in the Health Services Research Journal found that U.S. nursing homes underreported major injury falls. Comparing Medicare claims to the Minimum Data Set (MDS), where nursing homes self-report data on care, nursing homes only reported 57.5% of major injury falls in the MDS compared to those reported in Medicare claims. Further, reporting on these falls was significantly lower for nonwhite residents compared to White residents. The study states MDS data may be highly inaccurate, and in turn CMS quality measures can be inaccurate as CMS uses the MDS for calculating their quality measures.[135]

Some issues identified across all sources include:

- There are discrepancies in how incidents and other quality of care measures are reported; and
- The validity of some data used in CMS ratings are questionable.

Further, as states have varied measurements and requirements for nursing homes and their quality of care, it is hard to give a consistent measure of quality across all nursing homes in the Country. It may be more accurate to compare individual nursing homes to the average nursing home in their respective state, as Maryland's Health Care Quality website does.[136]

[133] "CMS Use of Data on Nursing Home Staffing: Progress and Opportunities to Do More".
[134] "Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated", Department of Health and Human Services Office of Inspector General (2019).
[135] "Assessment of Nursing Home Reporting of Major Injury Falls for Quality Measurement on Nursing Home Compare", Sanghavi, P., Pan, S., and Caudry, D., Health Services Research (2019).
[136] Feedback from MHCC, Maryland Quality Reporting Homepage.

Stakeholders interviewed by OLO suggest that many residents and families of residents do not use the CMS or Maryland quality of care ratings to determine which nursing home they go with. Often it is based on bed availability, insurance, and proximity of nursing home facility to family and friends.[137]

New York Times. Information from a 2021 New York Times article asserted that:

- CMS submitted incorrect information, which often made the nursing homes seem cleaner and safer than they are in reality;
- Some nursing homes inflated their staffing levels and other quality of care information, like underreporting the number of patients on antipsychotic medications;
- In the U.S., more than 3,500 homes were rated with four stars; however over 2,400 were cited for problems with infection control or patient abuse;
- Higher ratings were linked to higher profits, which incentivized nursing homes to inflate their numbers;[138] and
- There is a lack of oversight and auditing conducted by CMS.

C. The Maryland Health Care Commission (MHCC) Ratings

The MHCC is a regulatory agency independent from the Maryland Department of Health. The MHCC can make legislative recommendations and administers the Maryland Quality Reporting website, which reports data in a consumer-friendly way on various healthcare entities, including all nursing homes in the state.[139]

MHCC conducts an annual statewide survey called the Nursing Home Family Experience of Care Survey that is sent out to all families of residents. It obtains their satisfaction rates with the nursing home and MHCC reports the survey data on their Maryland Quality Reporting website. The survey includes 31 questions on seven main themes that are answered on a scale from 1 to 5:

1. Staff and Administration of the Nursing Home
2. Care Provided to Residents
3. Food and Meals
4. Autonomy and Residents' Rights
5. Physical Aspects of the Nursing Home
6. Activities (Quality and number of activities offered to residents)
7. Security and Residents' Personal Rights[140]

[137] Feedback from MHCC.
[138] "How U.S. Ratings of Nursing Homes Mislead the Public", Greenburg, J. and Gebeloff, R., New York Times (2021).
[139] Maryland Health Care Commission, About Us page.
[140] "Maryland Quality Reports: Maryland Annual Long Term Care Survey"

The Maryland Quality Reporting website reports the following data:[141]

1. **Quality Measures**. These measures are from the CMS Quality of Care measures and evaluate the way care is given and the results of that care.
2. **Experience of Care Measures.** These measures come from the results of the Nursing Home Family Experience of Care Survey. It evaluates how well a responsible party (e.g., close family member or friend), or the resident rated the care.
3. **Staffing Measures.** These measures come from the PBJ Journal, which is the same source that CMS receives their staffing data from. It shows how much time is spent with each patient per day, by different nursing staff and physical therapists, as well as percentage of staff that has been employed at a nursing home for two or more years.
4. **Results of Health and Fire Safety Inspection Reports.** The results from annual health and fire safety inspections conducted by OHCQ are posted for each nursing home. Each nursing home is required by law to have the latest survey results publicly available.
5. **Rates of Influenza Vaccination.** Annual data on the percentage of nursing home staff vaccinated for influenza is posted on the website. It compares the percentage of staff vaccinated in an individual nursing home to the statewide average.

[141] "Maryland Quality Reporting on Nursing Homes"

Chapter 4. Overview of Nursing Homes in Montgomery County

This chapter provides an overview of nursing homes in the County, including their location, information about their governance structure, and quality of care ratings. The demographics of older adults in the County and state are also discussed to identify the long-term care needs of older adult populations.

- **Section A** provides descriptive data about Montgomery County's older adult population and about nursing home residents in Maryland; and
- **Section B** discusses the 34 nursing homes located in Montgomery County, including their geographic location, ownership, and federal and state quality of care ratings.

A. Demographics of Older Adults

Older adults – defined in this section as anyone at or over the age of 65 – make up roughly 17% of the entire County population; out of 1,054,827 Montgomery County residents, 174,942 are 65 years and older. Data on the demographic characteristics of Montgomery County's older adult population from the 2021 American Community Survey show that:

- A little over half (56%) of older adults in the County are women;
- Almost two-thirds (59%) of all older adults in the County are White;
- 40% of older adults live alone and one in five are renters; and
- Most older adults in the County (77%) receive social security income and nearly one in ten are below 100% of the poverty line.

More detailed statistics about the population 65 years and older in Montgomery County can be found in Attachment 2.

Demographics of Nursing Home Residents. The Centers for Medicare and Medicaid (CMS) maintain a dataset called the Minimum Data Set (MDS) where data such as demographics on nursing home residents are reported. The Maryland Health Care Commission (MHCC) publishes these datasets for public consumption as they become available. The table on the next page summarizes the 2021 data, which was most recently available. The percentages from MDS data set may not total to 100% as there are missing data resulting from incomplete data entry.

In Maryland, over half of nursing home residents are women and nearly one-third of all residents are 85 years and older. Black and White residents make up most of the population in nursing homes, at 36% and 55% respectively. The table on the next page gives more descriptive statistics of the population in nursing homes in Maryland.

Table 4-1. Demographics of Nursing Home Residents in Maryland, 2021

Characteristics	Percent of Nursing Home Residents
Sex	
Male	42%
Female	58%
Age	
Less than 64	17%
Ages 65 – 75	25%
Ages 76 – 84	24%
85 and older	31%
Race/Ethnicity	
Asian	2%
Black or African American	36%
Hispanic	1.5%
White	55%
Multiracial	0.3%
Some other Race	0.3%

Source: 2021 Centers for Medicare and Medicaid Minimum Data Set

B. Characteristics of Nursing Homes in Montgomery County

This section gives an overview of nursing homes in Montgomery County, including geographic locations, types of ownership, and quality of care rankings.

1. Geographic Location and Ownership

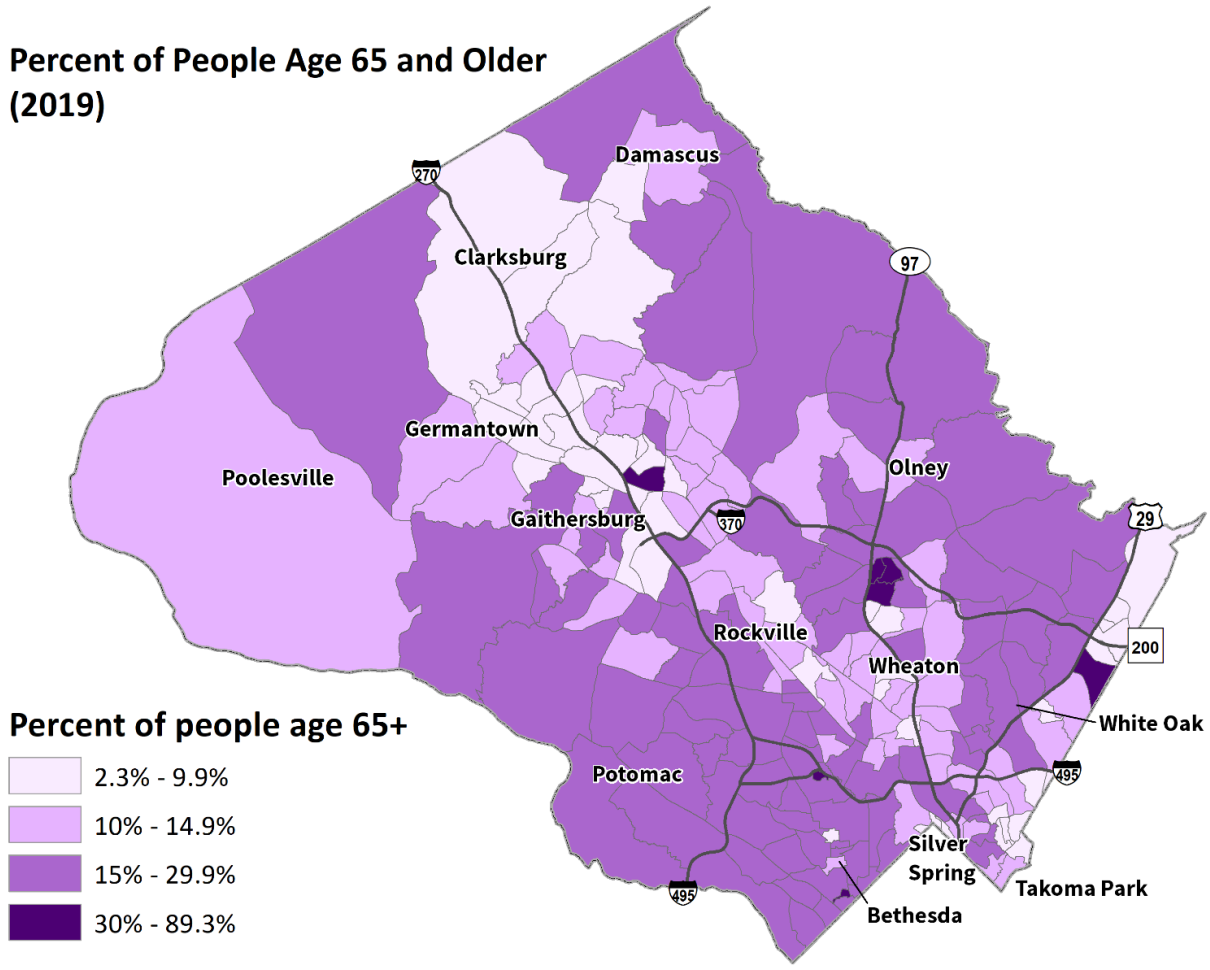
Montgomery County has 34 nursing homes comprised of 23 for-profit facilities and 11 non-profit facilities. More than half are in the eastern part of the County. Figure 4-1 shows the location of each nursing home in Montgomery County.

Figure 4-1. Geographic Distribution of Nursing Homes in Montgomery County

Source: QGIS Map Created by Office of Legislative Oversight

Figure 4-2 on the next page shows where older adults in the County are concentrated. While the map illustrates large numbers of older adults in the eastern portion of the Downcounty area, which is where most of the County's nursing homes are located (see Fig. 4-1), there are concentrations of older adults in the Upcounty area as well as the western portion, notably in the northeastern region above Poolesville.

Figure 4-2. Geographic Concentration of Older Adults in the County (by %)



Source: 2015-2019 American Community Survey, 5-year estimates, U.S. Census Bureau

Source: Montgomery County Planning Research and Strategic Projects[142]

[142] "Older Adults in Montgomery County: Data Snapshot", Montgomery County Department of Health and Human Services (2022).

The table below lists all 34 County nursing homes, their location, and ownership type, in alphabetical order.

Table 4-2. Nursing Homes in Montgomery County by Location and Ownership Type

Nursing Home Name	City	Ownership Type	
		For-Profit	Non-Profit
1. Althea Woodland Nursing Home	Silver Spring	✓	
2. Autumn Lake Healthcare at Arcola	Silver Spring	✓	
3. Autumn Lake Healthcare at Oakview	Silver Spring	✓	
4. Bedford Court Healthcare Center	Silver Spring	✓	
5. Bel Pre Healthcare Center	Silver Spring	✓	
6. Brooke Grove Rehabilitation and Nursing Center	Sandy Spring		✓
7. Cadia Healthcare of Springbrook	Silver Spring	✓	
8. Cadia Healthcare of Wheaton	Wheaton	✓	
9. Carriage Hill Bethesda	Bethesda	✓	
10. Collingswood Rehabilitation and Healthcare Center	Rockville	✓	
11. Friends Nursing Home	Sandy Spring		✓
12. Genesis Fairland	Silver Spring	✓	
13. Hebrew Home of Greater Washington	Rockville		✓
14. Ingleside at King Farm	Rockville		✓
15. Kensington Healthcare Center	Kensington	✓	
16. Layhill Nursing and Rehabilitation Center	Silver Spring	✓	
17. Maplewood Park Place	Bethesda	✓	
18. Montgomery Village Health Care Center	Gaithersburg	✓	
19. Oak Manor Center for Rehabilitation and Healthcare	Burtonsville	✓	
20. Peak Healthcare at Fox Chase	Silver Spring	✓	
21. Peak Healthcare at Sligo Creek	Takoma Park	✓	
22. Potomac Valley Rehabilitation and Healthcare	Rockville	✓	
23. Promedica Skilled Nursing & Rehab – Bethesda	Bethesda		✓
24. Promedica Skilled Nursing & Rehab - Chevy Chase	Chevy Chase		✓
25. Promedica Skilled Nursing & Rehab - Potomac	Potomac		✓
26. Promedica Skilled Nursing & Rehab - Silver Spring	Silver Spring		✓
27. Promedica Skilled Nursing & Rehab - Wheaton	Wheaton	✓	
28. Regency Care of Silver Spring	Silver Spring	✓	
29. Shady Grove Nursing and Rehabilitation Center	Rockville	✓	
30. Sterling Care Bethesda	Bethesda	✓	
31. Sterling Care Rockville Nursing	Rockville		✓
32. Tuckerman Rehabilitation and Healthcare Center	Rockville	✓	
33. Village at Rockville	Rockville		✓
34. Wilson Health Care Center	Gaithersburg		✓

2. Quality of Care Information

This section summarizes the current federal and state ratings for nursing homes in Montgomery County.

A. State Ratings

Maryland publicly publishes nursing home quality of care information on the website Maryland Quality Reporting. In addition to reporting federal ratings from the CMS website, the following information is also reported:

- **The Maryland Health Care Commission's Nursing Home Family Experience of Care Survey**: An annual survey sent to the families of all nursing home residents in the state. Family members are asked to rate their satisfaction with their loved one's nursing home over seven domains: staff and administration, care provided, food and meals, activities, autonomy and resident rights, physical aspects, and resident personal rights. The overall rating of the nursing home and the percentage of family members who would recommend the nursing home are recorded and all results are compared to the state average.
- **Maryland Medicaid Staff Stability**: Annual reporting of the percent of staff employed by the nursing home for two or more years.
- **Maryland Health Care Commission's Health Care Worker Influenza Vaccination Survey**: An annual survey that reports the percent of a nursing home's staff that are vaccinated against the flu along with the statewide average. Facilities with a rating of 95% or higher are indicated with a gold star.[143]

The table on the next page summarizes the results of the Family Experience of Care Survey, by the percent of family members that would recommend the nursing home and the overall care rating, averaged from the seven domains described above, rated from one to 10.

[143] As of 2022, MHCC has discontinued the influenza survey as CMS now tracks the vaccination rates of nursing home staff. Going forward, MHCC will report the federal survey instead.

Table 4-3. Nursing Home Ratings in Montgomery County by Family Recommendation and Overall Care Rating

Nursing Home	% Would Recommend Nursing Home	Rating of Overall Care (1-10)
1. Althea Woodland Nursing and Rehabilitation	77.8	7.4
2. Autumn Lake Healthcare at Arcola	84.6	8.1
3. Autumn Lake Healthcare at Oakview	87.5	7.8
4. Bedford Court Healthcare Center	100.0	8.8
5. Bel Pre Healthcare Center	45.5	5.2
6. Brooke Grove Rehabilitation and Nursing Center	92.5	8.4
7. Cadia Healthcare of Springbrook	92.9	8.1
8. Cadia Healthcare of Wheaton	54.5	6.8
9. Carriage Hill Bethesda	63.6	7.8
10. Collingswood Rehabilitation and Health Care Center	28.6	4.6
11. Friends Nursing Home	81.8	8.3
12. Genesis Fairland	81.8	6.9
13. Hebrew Home of Greater Washington	88.1	8.4
14. Ingleside at King Farm	100.0	9.5
15. Kensington Healthcare Center	53.3	6.3
16. Layhill Center for Nursing and Rehabilitation	42.9	6.3
17. Maplewood Park Place	100.0	9.6
18. Montgomery Village Health Care Center	50.0	5.8
19. Oak Manor Center for Rehabilitation and Healthcare	62.5	6.2
20. Peak Healthcare at Fox Chase	25.0	5.8
21. Peak Healthcare at Sligo Creek	58.3	6.2
22. Potomac Valley Rehabilitation and Healthcare Center	73.1	7.4
23. ProMedica Skilled Nursing and Rehabilitation - Bethesda	75.0	7.9
24. Promedica Skilled Nursing and Rehabilitation - Chevy Chase	70.4	7.2
25. ProMedica Skilled Nursing and Rehabilitation - Potomac	88.9	8.5
26. ProMedica Skilled Nursing and Rehabilitation - Silver Spring	71.0	7.6
27. ProMedica Skilled Nursing and Rehabilitation - Wheaton	71.4	7.4
28. Regency Care of Silver Spring	50.0	6.7
29. Shady Grove Nursing and Rehabilitation Center	55.0	6.5
30. Sterling Care Bethesda	71.4	7.0
31. Sterling Care Rockville Nursing	73.7	7.3
32. Tuckerman Rehabilitation and Healthcare Center	66.7	6.7
33. Village at Rockville	94.0	8.4
34. Wilson Health Care Center	94.7	8.8

The state average for percent of family members who would recommend the nursing home is 75.4% and the overall care rating is 7.5 out of 10. The following data compares nursing homes in the County to the state average :

- 20 nursing homes in the County are below the state average for the percent of family members who would recommend the nursing home;
- 14 nursing homes are above the state average for the percent of family members who would recommend the nursing home;
- 19 nursing homes are below the state average for the rating of overall care; and
- 15 nursing homes are above the state average for the rating of overall care.

The table on the next page describes the staff stability and the average time spent per patient per day with any licensed nurse (includes Licensed Vocational Nurses (LVN), Licensed Practical Nurses (LPN), and Registered Nurses (RN)). There is data missing for those nursing homes (marked NA) that did not self-report their staffing data to either the state Medicaid office or to CMS.

Table 4-4. Nursing Homes in Montgomery County by Nursing Time and Staff Stability

Nursing Home	Avg. time spent per patient per day with any licensed nurse (hrs.)	% of nursing staff employed for 2+ yrs. at this nursing home
1. Althea Woodland Nursing and Rehabilitation	NA	55.6
2. Autumn Lake Healthcare at Arcola	1.7	56.6
3. Autumn Lake Healthcare at Oakview	NA	66.3
4. Bedford Court Healthcare Center	2.0	NA
5. Bel Pre Healthcare Center	1.2	47.5
6. Brooke Grove Rehabilitation and Nursing Center	1.8	54.5
7. Cadia Healthcare of Springbrook	0.9	41.7
8. Cadia Healthcare of Wheaton	1.6	63.9
9. Carriage Hill Bethesda	1.7	47.6
10. Collingswood Rehabilitation and Health Care Center	1.6	49.6
11. Friends Nursing Home	1.5	54.8
12. Genesis Fairland	2.2	23.5
13. Hebrew Home of Greater Washington	1.8	81.9
14. Ingleside at King Farm	2.4	NA
15. Kensington Healthcare Center	1.4	76.3
16. Layhill Center for Nursing and Rehabilitation	1.6	39.8
17. Maplewood Park Place	3.0	NA
18. Montgomery Village Health Care Center	1.8	67.5
19. Oak Manor Center for Rehabilitation and Healthcare	2.4	53.2
20. Peak Healthcare at Fox Chase	1.2	22.0
21. Peak Healthcare at Sligo Creek	1.4	23.2
22. Potomac Valley Rehabilitation and Healthcare Center	1.4	41.3
23. ProMedica Skilled Nursing and Rehabilitation - Bethesda	1.4	38.6
24. Promedica Skilled Nursing and Rehabilitation - Chevy Chase	1.5	76.6
25. ProMedica Skilled Nursing and Rehabilitation - Potomac	1.6	68.8
26. ProMedica Skilled Nursing and Rehabilitation - Silver Spring	1.5	74.2
27. ProMedica Skilled Nursing and Rehabilitation - Wheaton	1.7	62.3
28. Regency Care of Silver Spring	1.6	56.5
29. Shady Grove Nursing and Rehabilitation Center	1.5	38.3
30. Sterling Care Bethesda	1.5	68.0
31. Sterling Care Rockville Nursing	1.3	46.1
32. Tuckerman Rehabilitation and Healthcare Center	2.0	NA
33. Village at Rockville	1.9	NA
34. Wilson Health Care Center	1.9	NA

In Maryland nursing homes, the average time spent per patient per day with any licensed nurse is 2.7 hours per day. The state average for percent of nursing staff employed for two or more years at an individual nursing home is 46%.[144,145] The following data compares nursing homes in Montgomery County to the state average:

- Out of the 32 of 34 nursing homes in the County that reported their average time spent per patient per day with any licensed nurse, 31 facilities had times below the state average;
- Only one nursing home in the County had a greater average time spent per patient per day with any licensed nurse compared to the state average;
- Out of the 28 of 34 nursing homes that reported their percent of nursing staff that were employed for two or more years, eight had percentages below the state average; and
- 20 nursing homes in the County had a greater percentage of nursing staff that were employed for two or more years compared to the state average.

B. Federal Ratings

Federal CMS ratings are based on an overall star rating – with one star being the lowest score and five being the highest – based on performance in three types of measures described below. Each of these measures are given individual star ratings and the overall star rating is a composite of three measures: (1) State Health Inspection Measures; (2) Staffing Ratio Measures; and (3) Quality Measures.

However, some measures are weighted differently. For example, if a nursing home received only one star for its state health inspection measure, then its overall star rating is capped at a maximum of two stars.[146] For a more in-depth explanation on CMS ratings, see chapter 3.

The CMS ratings for all 34 nursing homes in Montgomery County are summarized in the table below.

[144] "2021 Maryland Nursing Home Family Experience of Care Survey", Maryland Health Care Commission (2022).
[145] CMS began tracking staff turnover in 2022, so only one year of turnover data is available. However, data showed that nationally on average, nursing homes experience a turnover of about 52% of their staff each year. From "High Staff Turnover: A Job Quality Crisis in Nursing Homes", The National Consumer Voice for Quality Long-Term Care (2022).
[146] "Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical User's Guide".

Table 4-5. Federal CMS Ratings for Nursing Homes in Montgomery County

Nursing Home Name	Overall	Health Inspection	Staffing	Quality Measures
1. Althea Woodland Nursing and Rehabilitation	3	4	1	2
2. Autumn Lake Healthcare at Arcola	2	1	3	5
3. Autumn Lake Healthcare at Oakview	1	2	1	2
4. Bedford Court Healthcare Center	5	4	5	5
5. Bel Pre Healthcare Center	1	2	1	4
6. Brooke Grove Rehabilitation and Nursing Center	4	4	4	3
7. Cadia Healthcare of Springbrook	5	4	2	5
8. Cadia Healthcare of Wheaton	3	2	3	5
9. Carriage Hill Bethesda	3	2	2	5
10. Collingswood Rehabilitation and Health Care Center	4	4	2	3
11. Friends Nursing Home	5	5	4	4
12. Genesis Fairland	1	2	1	4
13. Hebrew Home of Greater Washington	5	4	5	5
14. Ingleside at King Farm	5	5	5	5
15. Kensington Healthcare Center	2	2	2	4
16. Layhill Center for Nursing and Rehabilitation	2	3	1	3
17. Maplewood Park Place	5	5	5	5
18. Montgomery Village Health Care Center	4	4	4	4
19. Oak Manor Center for Rehabilitation and Healthcare	3	4	4	1
20. Peak Healthcare at Fox Chase	1	2	1	4
21. Peak Healthcare at Sligo Creek	5	4	2	5
22. Potomac Valley Rehabilitation and Healthcare Center	2	2	2	3
23. ProMedica Skilled Nursing and Rehabilitation - Bethesda	3	4	1	2
24. ProMedica Skilled Nursing and Rehabilitation - Chevy Chase	4	4	4	4
25. ProMedica Skilled Nursing and Rehabilitation - Potomac	5	5	4	4
26. ProMedica Skilled Nursing and Rehabilitation - Silver Spring	4	4	4	4
27. ProMedica Skilled Nursing and Rehabilitation - Wheaton	3	3	4	3
28. Regency Care of Silver Spring	4	3	3	5
29. Shady Grove Nursing and Rehabilitation Center	1	1	2	3
30. Sterling Care Bethesda	4	3	3	5
31. Sterling Care Rockville Nursing	5	5	2	4
32. Tuckerman Rehabilitation and Healthcare Center	5	5	2	5
33. Village at Rockville	2	2	4	4
34. Wilson Health Care Center	5	4	5	3

Out of Montgomery County's 34 nursing homes:

- 18 nursing homes have an overall rating of 4 or 5
- 6 nursing homes have an overall rating of 3
- 5 nursing homes have an overall rating of 2
- 5 nursing homes have an overall rating of 1
- Overall, the lowest CMS measure was staffing, with an average score of 2.9.
- The highest CMS measure is the quality measures, with an average score of 3.9.

Further, two nursing homes recently cited with resident harm or potential harm for abuse or neglect by state inspectors were: Kensington Healthcare Center and Bel Pre Healthcare Center.[147] CMS defines abuse as the "willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse."[148]

[147] "Care Compare", U.S. Centers for Medicare and Medicaid Services, Accessed Feb. 19, 2023.
[148] "Preventing Abuse in Nursing Homes", U.S. Centers for Medicare and Medicaid Services, Accessed Feb. 19, 2023.

Chapter 5. Agencies and Departments that Support Nursing Homes and Nursing Home Residents in the County

As states enforce and carry out federal laws and requirements for nursing homes, Maryland's agencies play a key role in providing important resources to nursing facilities, their residents, and their families. Similarly, County government programs responsible for the health and well-being of all older County residents play an important part in serving the needs of those living in nursing homes. This section provides an overview of the agencies and departments that support nursing homes and nursing home residents in the County, and where appropriate, outlines County spending on these programs.

- **Section A** describes the state agencies and departments responsible for regulating nursing homes and their employees, as well as providing protective and support services to nursing home residents in Maryland;
- **Section B** discusses the Montgomery County departments and programs that provide services to nursing homes and nursing home residents as part of their overall activities; and
- **Section C** describes the County's Long-Term Care Ombudsman Program, which provides critical support to nursing home residents and their families by advocating for resident rights and quality of care.

A. State Agencies and Departments

The **Maryland Department of Health (MDH)** is the state agency responsible for public health issues.[149] Under its umbrella, it contains the Maryland Medicaid program. The main office contained within MDH that pertains to nursing homes is the **Office of Healthcare Quality (OHCQ)**. OHCQ is the CMS-designated state survey agency responsible for monitoring the quality of care in Maryland's nursing homes.

OHCQ's responsibilities include:

- issuing state licenses for nursing homes;
- conducting federally mandated surveys for nursing homes;
- investigating complaints; and
- issuing deficiencies to nursing homes.[150]

Outside of MDH, **The Maryland Health Care Commission (MHCC)** is an independent agency charged with writing the state's health plans, making legislative recommendations, and setting laws. In addition

[149] "About Maryland Department of Health,", Maryland Department of Health, Accessed Feb. 20, 2023.
[150] "Office of Health Care Quality,", Maryland Department of Health, Accessed Feb. 20, 2023.

to their regulatory duties, MHCC is also responsible for the state's health care website for consumers, called Maryland Quality Reporting, detailed in Chapter 3.[151]

The Maryland Department of Aging is a state agency that offers services to older adults to protect their rights and enhance their lives.[152] Some of its programs and offices relevant to nursing homes include the following:

- **Area Agencies on Aging** provide a variety of adult services, such as assisted living, protective services, temporary disability programs, and transportation services. Each County in Maryland has a local office to administer services to older adult residents.[153]
- **The Maryland Long-Term Care Ombudsman Program** oversees the local Ombudsman programs in all of Maryland's counties. Maryland has a decentralized system, with a state office and county satellite offices. About half of the states have this system, while the others have a centralized system with only a state office.[154]

Two state agencies license and regulate nursing home employees working in the State of Maryland:

- **The Board of Nursing** oversees nursing and has the authority to adopt regulations as necessary to carry out any provisions of the law. It provides licensure and certification for nurses working in facilities located in Maryland.[155]
- **The Board of Nursing Home Examiners** licenses, regulates, and disciplines nursing home administrators in the State of Maryland. Further responsibilities include developing and administering educational standards that must be met by individuals who seek to receive a license as a nursing home administrator.[156]

B. Local Agencies and Departments

The **Montgomery County Department of Health and Human Services (DHHS)** provides public health and human services for the County's most vulnerable children, adults, and seniors.[157] Within DHHS, **Aging and Disability Services** offers older adults, persons with disabilities, and their families a range of programs, home and community-based support services, protections, and opportunities that allow for dignified, independent, and inclusive living. The programs and services most relevant to nursing home residents and their families are:[158]

[151] Maryland Quality Reporting Homepage, Maryland Health Care Commission, Accessed Feb. 20, 2023.
[152] "About Us", Maryland Department of Aging, Accessed Feb. 2, 2023.,
[153] "Area Agencies on Aging", Maryland Department of Aging, Accessed Feb. 2, 2023.
[154] "Maryland Long-Term Care Ombudsman Program", Maryland Department of Aging, Accessed Feb. 2, 2023.,
[155] Maryland Board of Nursing Homepage, Maryland Board of Nursing, Accessed Feb. 2, 2023.,
[156] "Board of Examiners of Nursing Home Administrators", Maryland One Stop, Accessed Feb. 2, 2023.,
[157] "Department of Health and Human Services About Us, Montgomery County Government, Accessed Feb. 3, 2023.
[158] The budget amounts noted in this section reflect the County Council Approved FY23 appropriation for each program. Although not reflected here, subsequent supplemental appropriations may have modified the program appropriations beyond the amounts Council originally approved.

- **The Area Agency on Aging** provides a broad range of programs to help older adults remain independent in their communities, including senior meals, assisted living subsidies, and mobility and transportation, etc. The program most relevant to nursing homes is the **Long-Term Care Ombudsman**, which offers problem resolution for residents of both nursing home and assisted living facilities and is discussed in Section C of this chapter.

  *The FY23 Approved County Operating Budget allocates **$8,895,723** in expenditures for the Area Agency on Aging and **22.95 FTEs**,[159] which includes the addition of one full-time equivalent position to support the Long-Term Care Ombudsman Program due to increased caseload.*[160]

- **Aging and Disability Resource Unit** is the primary point of entry for most of the services within Aging and Disability Services. Staff personally assist older County residents, persons with disabilities, and their families and caregivers with determining what resources are available, how to access them, and where they can find additional services and support. Aging and Disability Resource Unit staff also conduct outreach and education events for older adults and people with disabilities, including meeting with clients at senior centers and at home as needed.[161]

  *The FY23 Approved County Operating Budget allocates **$1,091,377** in expenditures and **8.84 FTEs** for the Aging and Disability Resource Unit.*

- **Medicaid Funded Long-Term Care Services** administers and operates Maryland's Long-Term Care Medicaid Program, which many County residents use to cover nursing home stays. Staff determine initial and ongoing eligibility for individuals needing Long-Term Care Medicaid to help pay for their nursing home care.

  *The FY23 Approved County Operating Budget allocates the department **$8,964,232** in expenditures and **60 FTEs**.*[162]

The **Public Health Services** division within DHHS protects and promotes the health and safety of County residents through activities that include inspecting County facilities that affect public health and safety.

[159] This amount reflects the FY23 Approved Budget for the full services provided by Area Agency for Aging and not just for services related to nursing homes.
[160] "Aging and Disability Services", Montgomery County Operating Budget, Accessed Feb. 4, 2023.,
[161] "Aging and Disability Resource Unit", Department of Health and Human Services, Accessed Feb. 4, 2023.,
[162] This amount reflects the FY23 Approved Budget for the full services provided by Medicaid Funded Long-Term Care Services, which includes programs designed to allow people in need of long-term care to avoid institutionalization like Coordination of Community Services, and Community First Choice (CFC). "Aging and Disability Services - Medicaid Funded Long-Term Care Services Program", Montgomery County Operating Budget, Accessed Feb. 4, 2023.

- **Licensure and Regulatory Services** licenses and inspects over 22 County health and environmental programs, including healthcare facilities such as nursing homes. The office issues two County licenses to nursing homes: an annual food service license and a nursing home license.[163] The County nursing home license is issued after receiving a facility's completed application, which includes a copy of the state license and fees per bed.[164] Health Inspectors inspect a facility's kitchen and food serving areas before issuing a food service license.

  *The FY23 Approved County Operating Budget allocates Licensure and Regulatory Division Services **$5,108,400** in expenditures and **42.5 FTEs**.*[165]

1. Other Health Programs

The African American Health Program (AAHP), the Asian American Health Initiative (AAHI), and the Latino Health Initiative (LHI) are three DHHS health programs that focus on the "development of effective, culturally and linguistically appropriate policies and programs to begin to improve the health and well-being of racial ethnic and other under-served communities in the [C]ounty."[166]

The AAHP is the only program with a portfolio dedicated to older adults within the County's African American community. The Latino Health Initiative partners with local nonprofits to serve older adults and the AAHI has programming tailored to older adults.[167] When OLO spoke with the AAHP, they noted that it can be difficult to gain access to nursing homes, as many in the County are for profit and under no obligation to allow outside organizations inside their facilities to provide services.[168]

2. Montgomery County Commission on Aging

The Commission on Aging (CoA) advises the County Council, County Executive, DHHS, and other County departments on the needs of older adults in Montgomery County. The County established the CoA in 1974 as an Advisory Council to the Area Agency on Aging under the authority of the Older Americans Act.

[163] Feedback from County staff.
[164] Stakeholder Feedback.
[165] This amount reflects the FY23 Approved Budget for full services provided by Licensure and Regulatory Services and not just for services related to nursing homes. The budget decreased by $436 over the previous fiscal year due to multi-program adjustments such as changes in compensation and employee benefits, staff turnover, reorganizations, and other budget changes; "Public Health Services - Licensure and Regulatory Services Program", Montgomery County Operating Budget, Accessed Feb. 6, 2023.
[166] "Minority Health", Montgomery County Department of Health and Human Services, Accessed Feb. 6, 2023.
[167] Stakeholder Feedback, "AAHI Resource Library", Asian American Health Initiative, Accessed Feb. 6, 2023.
[168] Stakeholder Feedback.

Chapter 27, Article III of the Montgomery County Code outlines the CoA's duties as follows:[169]

- Improve conditions of the aging or elderly in the County;
- Work toward the elimination of restrictions that impede older citizens from full participation in the mainstream of community life; and
- Assist and stimulate all levels of government and the community to be more responsive to the needs of the County's older residents.

The County Executive appoints, and the County Council confirms the Commission's 18 members. A majority of the CoA's members must be age 60 and older and all members must be residents of Montgomery County.[170] The CoA works closely with County officials, staff, state and federal legislators, and members of the public to advance issues of interest to older adults in the County. It does this through advocating at all levels of the government for laws, policies, or programs that impact older adults, developing positions on budget and legislative priorities, and providing relevant testimony at County and state hearings. The CoA also conducts in-depth research to educate policymakers and the public on topics relevant to older adults such as affordable housing, transportation, home and community-based services, and Medicaid eligibility.[171]

Since 2021, when the State of Maryland terminated its Memorandum of Understanding with Montgomery County and absorbed all nursing home survey and inspection responsibilities into its Office of Health Care Quality, the CoA has been advocating at both the state and local level for more transparency and better reporting on state survey activities within nursing facilities in the County.

C. Montgomery County Long-Term Care Ombudsman Program

Long-Term Care (LTC) Ombudsman programs play a critical role in nursing home quality assurance by serving as advocates for residents. By law, LTC Ombudsman programs are neither regulatory nor enforcement entities. Instead, LTC Ombudsmen work as mediators and liaisons between residents, their families, facility staff, and government agencies to ensure residents receive the care they are entitled to.

Maryland's State LTC Ombudsman office oversees local Ombudsman programs in each county. In Montgomery County, the LTC Ombudsman is an independent program located within DHHS' Aging and Disability Services division. While the County supports some of the program's personnel through funding and human resources services, the program's operational work is fully directed by the State LTC Ombudsman.

[169] Montgomery County Code (MCC) § 27-35, Accessed 2/7/23.
[170] "Commission on Aging Montgomery County, Maryland 2021 Annual Report", Montgomery County Department of Health and Human Services (2022).
[171] "Commission on Aging" ; "Commission on Aging Montgomery County, Maryland 2021 Annual Report"

Staff and volunteers who are certified and designated as LTC Ombudsman representatives by both the County and State LTC Ombudsman provide program services to nursing home and assisted living residents. At the time of writing, the County LTC Ombudsman had eight active volunteers and was staffed by six full time employees and two part-time contractors. The office anticipated having four full-time positions by the end of March 2023. The following describes the status of these positions at the time of writing this report:[172]

- One Community Health Nurse position – interviews complete; waiting for the Office of Human Resources (OHR) to send an offer;
- One Program Manager position – interviews complete; waiting for OHR to send an offer;
- One Social Worker position – being reclassified as a Program Manager Position;
- One Program Manager position – will become vacant at the end of March 2023; will fill the vacancy when it occurs.

The County's FY23 Approved Operating Budget added one additional full-time Program Manager position to support the LTC Ombudsman program,[173] which was being created through OHR at the time of writing. The following table reflects the County's FY23 Approved Operating Budget for the full services provided by the Long-Term Care Ombudsman.

Table 5-1. County Long-Term Care Ombudsman Program FY23 Approved Budget

Fund	Personnel Costs	Operating Expenditures	Total	FTEs
General Fund	$ 680,490	$13,436	$693,926	6.08
Grant Fund*	$ 258,626	$20,878	$279,504	2.42
Total	**$ 939,116**	**$34,314**	**$973,430**	**8.50**

*Federal award passed-through the Maryland Department of Aging
Source: DHHS data

1. Legal Mandate

The federal Older Americans Act (OAA) mandates LTC Ombudsman programs and establishes an Office of the State LTC Ombudsman in every state, the District of Columbia, Puerto Rico, and Guam. The OAA requires State LTC Ombudsman programs to:[174]

- Identify, investigate, and resolve complaints made by or on behalf of residents;
- Provide information to residents about long-term supports and services;
- Ensure that residents have regular and timely access to ombudsman services;

[172] County LTC Ombudsman correspondence.
[173] "Aging and Disability Services".
[174] "Long Term Care Ombudsman Program", Administration for Community Living, Accessed Feb. 7, 2023.

- Represent the interests of residents before governmental agencies and seek administrative, legal, and other remedies to protect residents; and
- Analyze, comment on, and recommend changes in laws and regulations pertaining to the health, safety, welfare, and rights of residents.

The 2016 Long-Term Care Ombudsman Program Final Rule[175] gives states guidance on program implementation, including requiring that Ombudsman programs create a certification process for staff and volunteer training as well as for continuing education.[176]

2. Positive Impact of LTC Ombudsman Programs

National studies of LTC Ombudsman programs find they may help prevent negative outcomes for nursing home residents because ombudsmen are able to bring more quality issues to the attention of state regulators. One study found that the presence of ombudsmen was associated with increased levels of complaints and deficiency citations, while another notes that the "existence of a local [long-term care ombudsman program] is a significant predictor of quality of care, suggesting a positive preventative presence."[177]

Researchers note that LTC Ombudsman programs show positive impacts despite receiving modest funding from governments. However, studies also show that increased investment, including more funding, more paid staff, and smaller caseloads significantly increase the effectiveness of LTC Ombudsman programs.[178]

3. County LTC Ombudsman Program Functions

Montgomery County's LTC Ombudsman program has operated since 1977. Its mission is to be the voice of residents living in all 34 nursing homes and in more than 200 assisted living facilities in the County, though DHHS staff report most of the Ombudsman's services go toward helping assisted living residents.[179] LTC Ombudsman representatives advocate for residents through resolving individual complaints, addressing systemic issues, and advocating for laws, regulations, and policies.[180]

[175] "State Long-Term Care Ombudsman Programs" Federal Register (2015).,
[176] "Part 1324 - Allotments for Vulnerable Elder Rights Protection Activities", Code of Federal Regulations (2017).; "Final Long-Term Care Ombudsman Program Training Standards", Administration for Community Living (2019).
[177] "The National Imperative to Improve Nursing Home Quality" ; "The Impact of Long-Term Care Ombudsman Presence on Nursing Home Survey Deficiencies".; "State Long Term Care Ombudsman Programs: Factors Associated with Perceived Effectiveness", Estes, C., et. Al., The Gerontologist (2004).
[178] "The National Imperative to Improve Nursing Home Quality"; "State Long Term Care Ombudsman Programs: Factors Associated with Perceived Effectiveness"
[179] "Long Term Care Ombudsman Program"; DHHS correspondence.
[180] Long Term Care Ombudsman Program presentation to Montgomery County Council Health and Human Services Committee, December 3, 2020.

The functions of the County LTC Ombudsman include:[181]

- Visiting nursing homes in the County and meeting with residents in person to see their living conditions and hear their concerns;
- Educating residents and facility staff on policies and regulations, resident rights, and providing referrals to other state and County agencies for more information; and
- Providing testimony and/or comments on behalf of ombudsman programs on proposed legislation or at public hearings.

County LTC Ombudsman representatives investigate quality of care or quality of life complaints that residents or residents' family members bring to their attention. The complaint process is "consent driven," meaning a representative must first receive a resident's approval before working to resolve a complaint. Ombudsmen cannot report issues a resident does not want reported, regardless of the severity. Ombudsmen can encourage a resident to seek out services like law enforcement or adult protective services but must get a resident's permission before accessing such services on their behalf.[182] If an LTC Ombudsman representative finds a systemic issue at a facility that is affecting multiple people and is not centered on a single resident (e.g., a pattern of complaints about staffing, issues with insects/pests, etc.), they are not required to seek consent from every person involved before either investigating or attempting to resolve the issue with the facility.[183]

The County LTC Ombudsman also supports resident and family councils where they exist by working with council leaders to prepare for meetings, providing resources, guidance, and strategies for discussing certain topics, and ensuring councils receive adequate answers from the facility staff. Ombudsman representatives also try to attend monthly resident and family council meetings when invited, however staff report this can be difficult due to competing schedules.[184]

Prior to 2021, when County surveyors surveyed and inspected nursing homes in Montgomery County, the County LTC Ombudsman would connect local surveyors directly with active members of resident and family councils so they could better understand the continuing concerns of residents in those facilities. Staff report this process has broken down since the Maryland Department of Health terminated its Memorandum of Understanding with the County in 2021 and absorbed all facility survey and inspection responsibilities into the state Office of Health Care Quality.[185]

[181] State ombudsman interview; County ombudsman interview.
[182] Long Term Care Ombudsman Program presentation, December 3, 2020; State ombudsman interview.
[183] State ombudsman interview.
[184] County LTC Ombudsman correspondence
[185] County LTC Ombudsman correspondence; In February of 2021, the State of Maryland terminated the MOU between MDH and Montgomery County, citing that "there will be no funding for [the services provided under] the MOU after June 30, 2021." The work previously done by 8 to 10 County surveyors was absorbed by OHCQ, Maryland's designated survey agency. The state also retained the funding that would have supported the County surveyor team, causing the County's Department of Health and Human Services to lose those positions.

Because the County LTC Ombudsman program interacts with County residents in nursing homes and the larger long-term care environment, the program also works closely with other state and County programs that serve older County residents, including:[186]

- **Adult Protective Services** in Maryland's Department of Human Services, which investigates allegations of abuse, neglect, self-neglect and/or exploitation of vulnerable adults;
- **Adult Foster Care** in the County's Department of Health and Human Services, which provides supervised housing and case management for disabled adults;
- **Adult Public Guardianship** in Maryland's Department of Human Services, which provides surrogate decision making for disabled adults whom the Circuit Court has determined are incapacitated; and
- **The Maryland Medicaid Waiver Program**, which provides Medicaid coverage for home and community-based long-term care services.

4. Program Challenges

COVID-19 has significantly impacted the County LTC Ombudsman program's operations. Prior to the pandemic, the program had close to 50 volunteers and would average about 10,000 visitation hours in a year. Volunteers would visit nursing homes at least weekly, and staff would visit at least monthly. Today, the program is operating with just eight active and four inactive volunteers. According to County LTC Ombudsman staff, most of the program's volunteers are 70 years or older and chose to stop visiting long-term care facilities during the pandemic due to their high health risk factors. Staff report they currently do not have enough personnel or volunteers to handle the program's heavy workload.

Although County LTC Ombudsman operations continued throughout the height of the pandemic, the program was constrained in the type and frequency of visits they were able to conduct. In March 2020, CMS halted Ombudsmen and family visitation in nursing homes nationally, and the Maryland Department of Health extended the stoppage to assisted living facilities in the state. From March 2020 through April 2021, County LTC Ombudsman representatives conducted most of their facility visits virtually or by phone. According to the County LTC Ombudsman, this remote visitation resulted in two unintended consequences. First, resident complaints reduced significantly because under normal circumstances complaints were typically registered during onsite visits, which were no longer happening. Second, residents were experiencing increased isolation since Ombudsman program members were unable to visit them in person.[187] In February 2021, the State LTC Ombudsman initiated re-entry activities for local LTC Ombudsmen, and the County LTC Ombudsman program resumed in-person visits on a limited, as needed basis at the end of the 2021 federal reporting year.[188]

[186] County LTC Ombudsman interview; Department of Health and Human Services Crisis Contacts, Accessed Feb. 7, 2023.
[187] County LTC Ombudsman interview; Long Term Care Ombudsman Program presentation, December 3, 2020.
[188] County LTC Ombudsman interview; "Commission on Aging Montgomery County, Maryland 2021 Annual Report"

Currently, program staff report personnel and volunteer shortages are making it difficult to conduct even once a month in-person visits to long-term care facilities in the County. They are completing federally mandated quarterly visits in addition to continuing to conduct virtual visits with residents. Virtual visits, however, do not count for federal reporting purposes.[189] Of note, OLO spoke with representatives from the County's African American Health Program who said they were not aware of the Montgomery County Ombudsman making visits to nursing homes.

The following table summarizes data on County LTC Ombudsman operations presented to the County Council's Health and Human Services Committee in December 2020, and more recent operations data provided to OLO. The data show the significant impact COVID-19 had on functions of the County LTC Ombudsman program between Federal Fiscal Year 2019 and Federal Fiscal Year 2022.[190]

Table 5-2. Montgomery County LTC Ombudsman Program Statistics, FFY19 - FFY22*

Program Function	FFY19	FFY20	FFY21	FFY22
Complaints Closed	454 Total 303 Nursing Homes 103 Assisted Living	210 Total 194 Nursing Homes 16 Assisted Living	219 Total 189 Nursing Homes 30 Assisted Living	180 Total 150 Nursing Homes 30 Assisted Living
Facility Consultations/Facility Staff Information & Assistance	558	2,253	846	507
Information & Assistance to Individuals	1,529	1,503	2,046	999
Facility Visits Completed by Ombudsmen	3,218	1,053 (6 visits by exception between 3/16/20 – 12/03/20)	171	884
Time Donated by Certified/Designated Volunteers	5,215 Hrs.	2,072 Hrs.	1,185 Hrs.	856 Hrs.

Source: Long Term Care Ombudsman Program presentation to Montgomery County Council Health and Human Services Committee, December 3, 2020; County LTC Ombudsman program

*The LTC Ombudsman program operates and reports in a Federal Fiscal Year (FFY) cycle from October – September.

[189] The Administration for Community Living, the agency that provides federal oversight of LTC Ombudsman programs, defines "regular presence" for Ombudsman visitation as a licensed facility (nursing home or assisted living) receiving an advocacy visit by a certified and designated ombudsman at least once a quarter. County LTC Ombudsman interview.

[190] The LTC Ombudsman program operates and reports in a Federal Fiscal Year (FFY) cycle from October – September.

National Challenges. Research points to a lack of resources as being the biggest challenge facing State LTC Ombudsman programs across the country. A recent National Academies of Sciences report on nursing home quality found that ombudsman programs struggle with having sufficient funding, staff, and volunteers, citing the following statistics[191]:

- Only 23% of state ombudsmen report having sufficient financial resources;
- Only 27% of state ombudsmen report having sufficient staff; and
- Only 15% of state ombudsmen report having enough volunteers.

The research goes on to find that this lack of resources prevents LTC Ombudsman programs from fully carrying out their legally mandated functions like conducting routine access visits,[192] complaint visits,[193] retaining volunteers, maintaining inter-organizational relationships, supporting resident and family councils, and educating the community.[194]

[191] "The National Imperative to Improve Nursing Home Quality" ; "Protecting Rights and Preventing Abuse: Handling Resident Complaints in Long Term Care Facilities",Nguyen, K., Downie, S., and White, E., NORC at the University of Chicago (2019).

[192] The National Ombudsman Reporting System (NORS) defines "routine access" as a facility visited, not in response to a complaint, in all four quarters of the federal fiscal year by representatives of the LTC Ombudsman Office. "What is a Routine Access Visit", Long Term Care Ombudsman, Accessed Feb. 19, 2023.,

[193] "Complaint visits" are defined as an ombudsman visit made to a facility focused on investigation of a lodged complaint. Complaint visits were not collected in NORS prior to federal fiscal year 2020. County LTC Ombudsman interview.

[194] "Protecting Rights and Preventing Abuse: Handling Resident Complaints in Long Term Care Facilities"; "The National Imperative to Improve Nursing Home Quality"

Chapter 6. Issues Impacting Nursing Homes

OLO spoke with staff members in County departments, state agencies, nursing home associations, and partner organizations regarding the biggest challenges facing nursing homes, their residents, and their workers, and how they can be better supported in Montgomery County. Based on the observations shared by stakeholders and information gathered from the literature, OLO has identified five major issues impacting nursing homes, which are presented in this chapter.

- **Section A** describes the current healthcare workforce crisis and the factors contributing to nursing home worker shortages in the County;
- **Section B** describes how health disparities created by systemic racism and discriminatory policies have created inequities in both quality of care and patient outcomes for Black nursing home residents;
- **Section C** discusses the economic and social services older adults in the County need, whether they choose to age in their homes or in long-term care facilities;
- **Section D** describes how nursing home care is paid for in the United States and how inadequate Medicaid and Medicare payments have led to issues with quality of care and financial transparency in nursing homes; and
- **Section E** presents the growing influence of private-equity (PE) investment in nursing homes and how residents in PE-owned nursing homes are more likely to receive low quality of care and experience poor health outcomes.

A. Workforce Crisis

The staffing shortage among healthcare workers is one of the biggest public health crises currently facing the United States. While the issue has been growing for decades, the strain of the COVID-19 pandemic has exacerbated the problem by pushing many doctors, nurses, and other front-line caregivers out of health care altogether. In a March 2022 letter to the U.S. House of Representative's Energy and Commerce Committee, the American Hospital Association described the impact the last three years of the pandemic has had on the national healthcare workforce, noting that 23% of hospitals reported "a critical staffing shortage," and that "hospitals have seen a decrease of nearly 105,000 employees since February 2020."[195]

Recent data released by the Maryland Hospital Association's Task Force on Maryland's Future Health Workforce illustrates the extent of the healthcare workforce crisis in the state. The Taskforce found:[196]

- There are currently 86,555 active licensed registered nurses (RNs) in Maryland;

[195] "AHA Letter Re: Challenges Facing America's Health Care Workforce as the U.S. Enters Third Year of COVID-19 Pandemic", American Hospital Association (2022)
[196] "2022 State of Maryland's Health Care Workforce Report: Task Force on Maryland's Future Health Workforce".

- One in every four hospital nursing positions is vacant;
- 13,800 additional RNs and 9,200 additional licensed practical nurses (LPNs) are needed by 2035; and
- When surveyed, 62% of Maryland Board of Nursing licensees and certificate holders have recently thought about leaving nursing, due mainly to feeling overworked, burned out, and underappreciated.

OLO spoke with representatives from state and County agencies as well as nursing home associations, who all report that the workforce shortage is the number one challenge facing nursing homes in Montgomery County. These stakeholders note that the factors contributing to nurse shortages in the County are varied and often overlapping. The feedback OLO received includes:

- Nurses in the County are experiencing higher levels of stress and burnout due to increased workloads (e.g., going from a caseload of 10 patients to 20 patients),[197] which contributes to staff turnover;
- Because nursing jobs are physically challenging, demand long hours, and often do not offer competitive pay or benefits, many are choosing to leave the healthcare field altogether; and[198]
- The training and placement of new nurses in the County is constrained by a shortage of credentialed faculty,[199] severe testing backlogs, and a stricter certification requirement for nurses wanting to work in Maryland nursing homes.[200]

In addition to the factors above, research notes the healthcare workforce crisis is further complicated by a quickly aging national population that is demanding more skilled nursing care, both in homes and in nursing facilities. Finally, healthcare facilities are choosing to understaff to cut expenses amidst rising healthcare costs, inflation, and in the case of for-profit nursing homes, a drive to increase profit margins.

This section discusses factors most relevant to the nursing home workforce both nationwide and in the County:

- Understaffing;
- Poor Enforcement of Staffing Rules by Government Regulators;
- Poor Job Quality and High Turnover; and
- Barriers to Training and Recruitment.

[197] Interview with Nexus Montgomery.
[198] Ibid.
[199] Interview with the Health Facilities Association of Maryland.
[200] Interview with LifeSpan Network.

1. Understaffing

Understaffing has been a persistent problem in nursing homes despite decades of research showing that higher staffing levels are associated with better health and quality of life outcomes for residents.[201] For example, one study found that residents in facilities with higher RN staffing levels experienced fewer pressure ulcers, decreased infections, lower pain, and lower mortality rates.[202] A seminal 2001 staffing study by CMS found "a clear association between nurse staffing ratios and nursing home quality of care."[203] This finding led CMS to provide a staffing recommendation: facilities should provide a daily minimum of 4.1 hours of total direct nursing care per resident to maintain quality of care.

The consequences of inadequate staffing can be dire for nursing home residents. On average, Certified Nursing Assistants (CNAs) in nursing homes are responsible for 13 residents a shift by themselves, making it impossible to meet the recommended daily minimum of 4.1 care hours per resident.[204] In comments made during the National Consumer Voice for Quality Long-Term Care Conference, a Chicago-based CNA noted she could not turn a resident over every two hours (a directive often ordered by doctors to avoid patients developing bed sores) because she had 15 to 20 patients to care for.[205] Studies report residents in understaffed facilities are often unable to get assistance with toileting and personal care,[206] and a 2022 report by the Office of Inspector General of the U.S. Department of Health and Human Services also found residents living in poorly staffed nursing homes are more likely to be inappropriately drugged, leading to significant harm and sometimes death.[207]

Currently, there is no federal requirement for a minimum staffing standard in nursing homes. Federal regulations do require facilities to have an RN in the building for eight consecutive hours each day and a Charge Nurse on-site 24 hours each day. Otherwise, federal guidelines are vague, requiring facilities to have "sufficient nursing staff […] to assure resident safety and attain or maintain the highest practicable physical, mental, and psychological well-being of each resident..."[208] Healthcare advocates argue this lack of clarity allows each nursing home to decide for itself how many nurses qualify as "sufficient," and incentivizes them to keep staffing levels low to reduce costs.[209]

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[201] "State Nursing Home Staffing Standards: Summary Report", The National Consumer Voice for Quality Long Term Care (2021).
[202] "State Nursing Home Staffing Standards: Summary Report".
[203] "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes", Report to Congress from Centers for Medicare and Medicaid Services (2001).
[204] "High Staff Turnover: A Job Quality Crisis in Nursing Homes".
[205] Conference presentation, "Quality Jobs, Quality Care: The Role of Labor Organizations in Improving the Quality of Resident Care," National Consumer Voice for Quality Long-Term Care 46th Annual Conference, November 15, 2022.
[206] "Many Nursing Homes are Poorly Staffed. How Do They Get Away With It?", Fraser, J. and Penzenstadler, N., USA Today (2022).
[207] "Long Term Trends of Psychotropic Drug Use in Nursing Homes", U.S. Department of Health and Human Services Office of Inspector General (2022).
[208] 42 C.F.R. § 483.35(a)(1).
[209] "State Nursing Home Staffing Standards: Summary Report"

In the absence of federal staffing requirements, many states have developed their own nursing home staffing minimums which vary greatly, and in most cases, fall below CMS's recommended level of 4.1 hours per resident per day (hprd). Maryland requires a minimum of 3 hprd of total nursing staff time and RNs in Maryland must only meet a minimum of 0.36 hprd compared with the recommended federal minimum of 0.75 hprd.[210]

The variance between state staffing minimums and the more lenient federal guidelines can cause nursing homes to receive high overall ratings even if they fall below the minimum requirement for staff hours in the state. For example, OLO analyzed CMS's ratings for the 34 nursing homes in Montgomery County and found:[211]

- Staffing was the lowest CMS measure for nursing homes in the County, with an average score of 2.9 out of 5;
- One in five nursing homes in the County have a staffing rating of 1; and
- Most facilities in the County scored an overall star rating of 4 or 5.

New Federal Minimum Staffing Standards. Advocates argue the answer to chronic understaffing in nursing homes is to strengthen federal standards.[212] In February 2022, the Biden Administration called for the establishment of a new federal minimum staffing standard for nursing homes. CMS is currently determining what that minimum standard should be and the agency intends to publish proposed rules on minimum staffing requirements for skilled nursing facilities in 2023.[213]

While advocates for the new federal staffing standard say it will significantly increase protections for nursing home residents, some policymakers and many in the nursing home industry argue that imposing staffing mandates on nursing homes will only cause more harm to residents. They contend that nursing homes are already struggling to operate because Medicaid and Medicare reimbursements – which most residents use to pay for their stays – do not cover growing inflation and labor costs.[214] Long-Term Care industry groups argue that adding staffing requirements without the financial resources to help meet them will only compound this challenge.
Moreover, many claim this solution ignores the core problem facing nursing homes, which is staff recruitment and retention.[215] In January of this year, a group of U.S. senators from rural states asked President Biden not to establish a federal minimum standard, saying "blanket staffing standards may

[210] 10.07.02.19, Code of Maryland Regulations (COMAR), ; "State Actions to Address Nursing Home Staffing During COVID-19", KFF (2022).
[211] See Table 4-5, Chapter 4.
[212] "Staffing in Nursing Homes", The National Consumer Voice for Quality Long-Term Care.
[213] "Centers for Medicare and Medicaid Services Staffing Study to Inform Minimum Staffing Requirements for Nursing Homes", U.S. Centers for Medicare and Medicaid Services (2022).
[214] "Help Us Hire, Don't Require"
[215] Ibid.

not provide enough flexibility to nursing homes in light of well-known and long-standing obstacles to the recruitment and retention of direct care workers, especially in rural and underserved areas."[216]

2. Poor Enforcement of Staffing Rules by Government Regulators

Analysts note that even if the federal government imposes new staffing minimums, it will do little to solve inadequate staffing in nursing homes without proper enforcement. They contend that the government's track record for enforcing existing rules and expectations for nursing home staffing has fallen short for many years.[217] An analysis of millions of nursing home timesheets and government inspection reports by USA Today found that even though more than three quarters of all nursing homes in the United States (11,757 facilities) had fewer nurses and aides in 2021 than expected,[218] regulators only cited 5% (589 facilities) for understaffing.[219]

The USA Today study points to feedback from hundreds of regulators who described rarely citing facilities for staffing violations because "staffing citations were not a priority set by department leaders."[220] Another study explains that surveyors rarely sanction nursing homes for understaffing because they classify almost all staffing deficiencies (96%) as "not causing harm." Even when regulators find that staffing deficiencies pose an "immediate jeopardy" to residents – which occurs rarely according to researchers – facilities are not often penalized.[221]

Staffing Challenges among Regulators. Research points to ongoing staffing challenges in state survey agencies, which leads to inadequate oversight and higher instances of quality-of-care issues in nursing homes. In May 2023, the U.S. Senate Special Committee on Aging released a report titled *Uninspected and Neglected* that found state survey agencies across the country are severely understaffed. The study cited 32 survey agencies with vacancy rates for nursing home surveyors of 20% or higher; nine of the 32 agencies had vacancy rates of 50% or higher. The report concluded decades of underfunding from the federal government has led to these vacancies, which are causing significant delays in nursing home inspections and placing nursing home residents at heightened risk.[222]

In testimony before the U.S. Senate Special Committee on Aging, Erin Bliss, the Assistant Inspector General of the U.S. Department of Health and Human Services Office of Inspector General, explained

[216] "Senators Call on CMS to End Push for Mandatory Staffing in Nursing Homes", Towhey, J., Mcknights Long Term Care News (2023).
[217] "Time to Ensure Sufficient Nursing Home Staffing and Eliminate Inequities in Care", Harrington, C., et. al., HSOA Journal of Gerontology and Geriatric Medicine (2021).
[218] The expected number of nurses and aides is determined using a staffing formula CMS uses to calculate both Medicare payments and quality ratings.
[219] "Many Nursing Homes are Poorly Staffed. How Do They Get Away With It?"
[220] Ibid.
[221] "Time to Ensure Sufficient Nursing Home Staffing and Eliminate Inequities in Care"
[222] "Uninspected and Neglected: Nursing Home Inspection Agencies are Severely Understaffed, Putting Residents at Risk,", The Majority Staff of the U.S. Senate Special Committee on Aging (2023).

that COVID-19 caused significant backlogs in standard nursing home surveys across state agencies and these backlogs persist in many states.[223] Bliss testified that as of May 2023, CMS data showed 28% of nursing homes across the country have gone at least 16 months without a standard survey. According to Bliss, "by state, the backlogs range from less than 1 percent to as high as 87 percent, with Kentucky and Maryland each facing a backlog of 80 percent or greater."[224]

Research also finds that states' inability to offer competitive salaries is a major reason for the difficulty in attracting and maintaining adequate numbers of qualified state surveyors.[225] Data from the Bureau of Labor Statistics show that survey agencies have not been able to keep up with increases in nursing salaries, which have gone up by 21% in the last ten years.[226] To cover staffing shortfalls, states are resorting to hiring expensive contract inspectors, requiring surveyors to work overtime, and having surveyors cover larger geographic regions. These strains on the workforce can threaten the safety of nursing home residents.[227]

Concerns with State Inspections of Nursing Homes in the County. OLO spoke with County representatives who expressed concerns that state enforcement of nursing homes in the County is being impacted by staff shortages at the Office of Health Care Quality. In February of 2021, the State of Maryland ended its long-standing Memorandum of Understanding with Montgomery County that allowed County surveyors to conduct inspections of nursing homes in the County on behalf of the state. Five and a half state surveyors absorbed the work that had been previously done by an eight to 10-person County survey team. In a letter sent to the Montgomery County Commission on Aging (CoA), OHCQ explained that the agency would grow their long-term care survey staff by 10 new positions in FY22 and FY23.[228] OLO has been unable to speak with OHCQ representatives to confirm the progress of developing these new positions.

Over the course of 2021, County representatives grew concerned that state enforcement efforts in Montgomery County were lagging. The CoA was specifically concerned that of the 33 nursing homes in the County at the time, no annual surveys and only six complaint surveys had been conducted since July 1, 2021. In response to data requests from the CoA and Maryland State Delegate Kirill Reznik, OHCQ reported it conducted 172 surveys (consisting of annual surveys, complaint surveys, COVID reporting surveys, emergency preparedness surveys, focused infection control surveys, inspection surveys, and other audits) at 33 nursing homes in the County between July 1, 2021 and September 14, 2022.

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[223] "Residents at Risk: The Strained Nursing Home Inspection System and the Need to Improve Oversight", Bliss, E., Testimony Before the United States Senate Special Committee on Aging (2023).; Calculated at S&C QCOR

[224] Ibid.

[225] "CMS Should Take Further Action to Address States with Poor Performance in Conducting Nursing Home Surveys", U.S. Department of Health and Human Services Office of Inspector General (2022).

[226] "Wages and Salaries Cost Per Hour Worked for Civilian Worker in Registered Nurse Occupations", BLS Data Viewer, Bureau of Labor Statistics (2022)..

[227] State Survey Agency Letter from Congress, September 12, 2022

[228] Ibid.

It also reported "imposing 43 civil monetary penalties (CMPs) on nursing homes for noncompliance with COVID reporting requirements as well as 14 CMPs related to other federal and/or state regulations."[229] OHCQ did not specify which federal and/or state regulations had been violated however, nor did it clarify whether the enforced penalties resulted from investigated complaints.[230]

3. Poor Job Quality and High Turnover

Researchers cite poor job quality, fueled by crushing workloads, poor management, lack of training, and poor compensation and benefits, as a leading cause for high staff turnover in nursing homes.[231] CMS data reveal the average nursing home in the country replaces half of its direct care nursing staff (52%) every year.[232] In the average nursing home in Montgomery County, almost half (47%) of nursing staff are employed for less than two years.[233]

Importantly, these factors disproportionately impact women of color and immigrants, who make up most of Maryland's nursing home workforce – 95% of nursing home direct care staff in Maryland are women, nearly 80% are people of color, and 31% are either naturalized U.S. citizens or citizens of another country.[234]

National studies on nursing home wages and benefits found that in 2020, nearly two thirds of nursing home staff did not have paid leave, and a quarter of CNAs in nursing homes get health insurance through Medicaid.[235] In Montgomery County, the median annual salary for a Geriatric Nursing Assistant (GNA) in a nursing home is $34,026.[236] The median annual salary for Registered Nurses (RNs) working in nursing homes in the County is $74,595, but RNs working in hospital emergency rooms in the County make 12% more.[237] In discussions with OLO, stakeholders repeatedly mentioned how nursing homes in Montgomery County and across Maryland have trouble attracting and retaining nursing staff because hospitals can afford to pay candidates more money.[238]

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[229] Letter from Maryland Department of Health, September 13, 2022.
[230] Correspondence from Maryland Office of Health Care Quality.
[231] "High Staff Turnover: A Job Quality Crisis in Nursing Homes"; "Employee Turnover in the Long-Term Care Industry", Bryant, O., Walden Dissertations and Doctoral Studies (2017).; "Predicting Nurses' Turnover Intentions by Demographic Characteristics, Perception of Health, Quality of Work Attitudes", Al-Hussami, M., et. al., International Journal of Nursing Practice (2013).; "Enhancing Transition to Workplace", Negarandeh, R., Nurse Midwifery Studies (2014). ; "The National Imperative to Improve Nursing Home Quality"
[232] "High Staff Turnover: A Job Quality Crisis in Nursing Homes"
[233] See Table 4-4, Chapter 4.
[234] "Direct Care Workers in the United States: Key Facts", PHI (2022).
[235] "High Staff Turnover: A Job Quality Crisis in Nursing Homes"
[236] Data from ZipRecruiter.com, with Rockville, MD used as proxy for Montgomery County.
[237] Data from Salary.com for Nursing Home Registered Nurse Salary with Rockville, MD used as a proxy for Montgomery County.; Data from Salary.com for Emergency Room Registered Nurse Salary with Rockville, MD used as a proxy for Montgomery County.
[238] Interview with Health Facilities Association of Maryland (HFAM).

Many nurses have also turned to independent travel nursing agencies for higher pay. Travel nurses are RNs and CNAs who temporarily fill open positions at healthcare facilities. Nursing homes often pay travel nurses more money and cover housing and relocation costs, making it an attractive employment option for nurses. However, paying for travel nurses is more expensive for nursing homes due to these added benefits, and the temporary nature of travel nurses creates discontinuity within facilities' staff and with residents' care.

A 2022 report by The National Governors Association Center for Best Practices (NGA Center) examines how some states are using Medicaid policy to increase wages for nursing home workers. As discussed later in this chapter, Medicaid is the largest payer for long-term care in nursing homes. Medicaid reimburses long-term care providers, like nursing homes, for daily patient care. The NGA Center report finds states are implementing two types of strategies to boost pay for care workers:[239]

1. **Wage Passthrough:** this approach increases Medicaid reimbursement rates for long-term care providers with the requirement that providers pass on a percentage of the increase directly to care workers' wages and benefits. States implementing this approach include Connecticut, Iowa, Kansas, and Rhode Island. The Maryland General Assembly has proposed wage passthrough legislation that would increase the Medicaid reimbursement rate by 10%.[240]
2. **Wage Floor:** this approach increases Medicaid reimbursement rates to establish a minimum wage, or wage floor, for direct care workers. Florida, Louisiana, and New Jersey are implementing versions of this policy strategy.

4. Barriers to Training and Recruitment

OLO spoke with nursing home industry representatives who noted that to address high turnover, the state and County must find better pathways to train and recruit new nurses and aides into the health care market.[241] The pipeline of new nurses in the County is currently being impacted by a shortage of nursing faculty, testing backlogs, and stricter state certification requirements.

According to a representative from the Health Facilities Association of Maryland, a trade association for long-term and post-acute care providers in Maryland, nursing programs across the state are turning potential students away because of a shortage of faculty with doctoral or master's degrees. Some factors contributing to the shortage include a spate of faculty retirements and nursing graduates choosing to take higher-paying clinical and private-sector jobs instead of becoming educators.[242]

[239] "Addressing Wages of the Direct Care Workforce Through Medicaid Policies" (2022).
[240] SB0468 Funding for Wage Increases for Medical Provider Workers, Introduced in the General Assembly of Maryland on February 3, 2023.
[241] Interview with LifeSpan Network.
[242] "Nursing Faculty Shortage," American Association of Colleges of Nursing; Interview with HFAM.

Stricter certification requirements in Maryland. Stakeholders also note Maryland's Geriatric Nursing Assistant (GNA) certification requirement is a barrier to getting more nursing assistants into nursing homes in the County. Unlike other states, Maryland requires all nursing assistants who work in licensed comprehensive care facilities (i.e., nursing homes) to pass the state's GNA examination in addition to receiving a basic CNA certification.[243] Stakeholders argue the state should consider eliminating the GNA certification requirement because it discourages CNAs from entering Maryland's nursing home workforce and places nursing homes in the state at a competitive disadvantage for attracting desperately needed staff.[244]

GNA certification requires individuals to complete an additional 75-hour training program that can be costly and conflict with home and work schedules. It also requires the individual to pass the GNA exam, which is difficult due to a nearly four-month testing backlog. Instead of waiting for GNA certification, stakeholders say CNAs are choosing to instead work in home care, assisted living communities, or hospitals, often for more competitive wages than in nursing homes. They may also choose to leave Maryland to work for nursing homes in states that do not require GNA certification.[245]

Stakeholders also recommend that the Maryland Board of Nursing allow a nursing aide's work experience to count toward their training requirements. During the COVID-19 pandemic, CMS waived the certification requirement for nursing aides, allowing temporary nurse aides (TNAs) with less experience to work in nursing homes. CMS extended the waiver until the end of the federal Public Health Emergency, which was May 11, 2023[246], allowing TNAs to continue to work while they seek CNA/GNA certification.[247] Stakeholders contend this real-world, hands-on work experience will make TNAs better nurses in the long run, and therefore should count toward their CNA/GNA certification requirements.[248]

B. Racial Disparities

Centuries of systemic and institutional racism in this country has created disparities in nursing home services and health outcomes by race. Discriminatory laws and practices resulting in geographic segregation, such as racially restrictive housing covenants and "redlining," have negatively impacted

[243] OLO did not find a similar GNA requirement for nurses to work in nursing homes in other states. Missouri does require that 1 DON RN with training in gerontology is included in a nursing home's 1 RN/LPN 24 hours/7 days a week staffing schedule.
[244] Interview with LifeSpan Network.
[245] Ibid.
[246] TNAs now have until September 10, 2023 to obtain certification as a CNA/GNA in the State of Maryland to continue working.
[247] "Temporary Nurse Aide Pathway for CNA/GNA Certification", Maryland Board of Nursing, Accessed Mar. 20, 2023.
[248] Interview with LifeSpan Network.

where and how communities of color, particularly Black communities, live, work, go to school, and access health care.[249]

These factors, also referred to as social determinants of health, have been key drivers of poor health outcomes consistently seen in communities of color. According to the Center for Disease Control and Prevention, when compared to individuals from White communities, individuals from Black, Indigenous, and other people of color (BIPOC) communities experience higher rates of illness and death from conditions like diabetes, hypertension, obesity, asthma, and hearth disease.[250] These health disparities accumulate over the course of a lifetime to create inequities in patient outcomes in nursing homes.[251]

National data on nursing home demographics show that Black older adults are overrepresented in nursing homes, making up just 8.3% of the general population aged 65 and over, but 14.3% of the national nursing home population.[252] Numerous studies show that Black nursing home residents receive lower-quality care and experience worse health outcomes than White residents. For example, when compared to White residents, Black nursing home residents are:[253]

- More likely to be physically restrained;
- More likely to develop severe pressure ulcers;
- More likely to be hospitalized for conditions associated with not receiving proper care (e.g., poor nutrition, dehydration, bedsores, etc.);
- Given influenza vaccines less often;
- Treated for pain less often; and
- More likely to report lower quality of life.

The COVID-19 pandemic, which disproportionately impacted BIPOC nursing home residents, brought these health disparities to the forefront. In 2020, researchers from the University of Chicago found a "strong and consistent relationship between race and the probability of COVID-19 cases and deaths.

[249] After slavery, Blacks could only visit deteriorated public hospitals that were typically reserved for the poorest residents. By the 1920s, there was a limited number of segregated clinics for Blacks that were usually operated by Black physicians. It was not until the 1964 Civil Rights Act and the passage of Medicare and Medicaid in 1965 that BIPOC were able to receive access to a wider range of healthcare services and facilities.

[250] "Racism and Health: Racism is a Serious Threat to the Public's Health", Centers for Disease Control and Prevention, Accessed Mar. 20, 2023.

[251] "Separate and Unconscionable: A Report on Racial and Ethnic Disparities in Pennsylvania's Nursing Homes with Recommendations for Immediate Action", Center for Advocacy for the Rights and Interests of Elders (2021).; "The National Imperative to Improve Nursing Home Quality"

[252] "Black - White Disparities in Moves to Assisted Living and Nursing Homes Among Older Medicare Beneficiaries", Morales, M. and Robert, S., The Journals of Gerontology: Series B (2020).

[253] "Separate and Unconscionable: A Report on Racial and Ethnic Disparities in Pennsylvania's Nursing Homes with Recommendations for Immediate Action"; "The National Imperative to Improve Nursing Home Quality"; "Addressing Systemic Racism in Nursing Homes: A Time for Action", Sloane, P., et. al., Journal of the American Medical Directors Association (2021).

Nursing homes with the lowest percent of [W]hite residents were more than twice as likely to have COVID-19 cases or deaths as those with the highest percent [W]hite residents."[254]

Racially disparate health outcomes for nursing home residents are greatly influenced by unequal access to quality care. Black people are much more likely than Whites to live in historically poor performing nursing homes, which are often located in predominantly Black neighborhoods.[255] These nursing homes are more likely to have been terminated from Medicare and Medicaid, have lower star ratings, and have fewer staff. At the same time, Black nursing home residents are less likely to file complaints about the quality of nursing home care to ombudsmen or others.[256] A study looking at racial disparities among older adults who relocate to assisted living and nursing homes notes that systemic biases can contribute to disparities in the information communities of color receive about quality long-term care options. For example, Black families may not hear about assisted living facilities if long-term care marketing campaigns assume they cannot afford them and only target White, wealthier families. The report argues this ultimately limits the range of choices Black older adults have for quality long-term care settings.[257]

Challenges with long-term care services for Black older adults in the County. OLO spoke with representatives from the County's African American Health Program (AAHP), who described disparities in health outcomes and support services they have seen with older Black residents in the County. These disparities include:

- Black patients in long-term care facilities in the County who have histories of falling and/or are at an increased risk of falling do not get the care they need because the facility lacks proper equipment and/or has an inadequate staffing ratio.
- Many Black residents in long-term care facilities in the County do not receive culturally appropriate care or services due to a lack of cultural competence.[258] For example, some Black residents who want to participate in their religion cannot because the facility does not provide certain religious services on site.

[254] "Caring for Senior Amid the COVID-19 Crisis", Testimony of R. Tamara Konetzka, PHD before the United States Senate Special Committee on Aging (2020).
[255] "Addressing Systemic Racism in Nursing Homes: A Time for Action"
[256] "Separate and Unconscionable: A Report on Racial and Ethnic Disparities in Pennsylvania's Nursing Homes with Recommendations for Immediate Action"; "The National Imperative to Improve Nursing Home Quality"
[257] "Black - White Disparities in Moves to Assisted Living and Nursing Homes Among Older Medicare Beneficiaries"
[258] Cultural competence in nursing refers to the ability of healthcare workers to be knowledgeable of and demonstrate cultural awareness for a patient's beliefs, race, and values in all aspects of their care and treatment. Examples of providing culturally competent care include having someone on a patient's care team who speaks their language, supporting a patient's beliefs or religious background, and/or providing food that complies with a patient's cultural or dietary restrictions. Definition from: "The Importance of Cultural Competence in Nursing", The Chicago School of Professional Psychology (2020)..

- Older Black residents do not have the same access to County programs or activities as White residents do. Many complain they feel left out of County activities that cater more to White seniors. For example, the County government frequently offers programming in retirement communities like Leisure World, but due to years of racist government policies that prevented Black families from owning homes and accumulating wealth, many Black seniors in the County cannot afford to live in retirement communities and are therefore left out of senior programs.
- There is a need for more cultural competence within County programs that serve older adults. Older adults from communities of color seeking County services like aging in place, home based care, or nursing homes, often feel more comfortable navigating these services – which can be numerous and hard to understand – with someone of their own race and/or ethnicity.

In addition to the challenges above, representatives from AAHP highlighted that they do not have enough information about what County resources are available to residents living in nursing homes and how best to access those resources. They expressed a need for better communication between County departments like Aging and Disability Services and AAHP so they can help residents in long-term care and their families better navigate aging and care services.

C. Economic and Social Supports for Older Adults

Older adults are one of the fastest growing demographics in the United States. In 2019, there were 54.1 million older adults (age 65 and older), about a 37% increase from 2009. By 2040, it is projected there will be 80.8 million older adults in the U.S.[259] In order to serve this growing demographic, it is essential to have necessary economic and social supports for older adults, so they can choose to age in a manner that makes sense for them, whether it is in their homes or in a facility with 24/7 nursing care.

Affording Long-Term Care. Many older adults depend on Medicare to cover their health costs. However, Medicare does not cover the costs of daily long-term care, such as nursing homes or home-based health care. Many older adults are left paying out of pocket, which can be costly as the median yearly cost of a private room in a nursing home was $105,850 in 2020.[260] Low-income older adults can qualify for Medicaid to cover healthcare costs, however for those wanting to age in place with home healthcare, there is an extensive waitlist that has an average wait time of more than three years to receive services through Medicaid.[261]

Because of historic and persistent racial inequities, BIPOC older adults, especially Black older adults, have experienced disparate outcomes in health care, housing, and generational wealth, compared to

[259] "Projected Future Growth of Older Population", Administration for Community Living, Accessed Mar. 4, 2023.
[260] "The Staggering, Exhausting, Invisible Costs of Caring for America's Elderly", Vox (2021).
[261] "Disability Digest", From the Office of U.S. Senator Bob Casey (2020).

their White counterparts.[262] This has led to a greater share of BIPOC adults needing to rely on Medicaid for healthcare costs. For long term care, BIPOC older adults are more likely to rely on Medicaid for their nursing home care and are about 2.5 times more likely than White residents to live in nursing homes that primarily serve individuals that rely on Medicaid.[263] Research shows that facilities that predominantly serve Medicaid residents are more likely to have lower quality of care and challenges with compliance with federal and state regulations.[264]

Further, nursing homes will need to increase the number of available beds to keep up with future demand. A study conducted by the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation estimated that more than half of adults in the United States are projected to need long-term services and supports once they reach the age of 65 and older, and more than one-third will need nursing home care.[265] However, according to an extensive report released by the National Academies of Sciences, Engineering, and Medicine, the current nursing home system is unsustainable.[266] In general, the business model for nursing homes depends on having a high occupancy rate to generate a profit through Medicare and Medicaid reimbursements and stay in business. However, the pandemic has caused occupancy rates to decline dramatically, and this has led to a decrease in the number of beds available as well as the closure of some nursing homes.[267] This could lead to an even greater shortage of available healthcare services for older adults.

Services for Nursing Home Residents in Montgomery County. OLO was informed by County staff about gaps in services for nursing home residents, such as transportation, mental health services, and religious services. Multiple County staff shared concerns that once older adults enter nursing homes, they are often forgotten about and excluded from programs and activities that the County provides for older adults. This is due in part, to an assumption that nursing home residents are receiving services through their respective facilities. However, the range of services offered to residents varies by nursing home, and County staff are concerned there are many County residents residing in nursing homes who are not receiving services they could greatly benefit from.[268]

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[262] "Implicit Bias and Racial Disparities in Health Care", Bridges, K., American Bar Association, Accessed 3/3/23.
[263] "Separate and Unconscionable: A Report on Racial and Ethnic Disparities in Pennsylvania's Nursing Homes with Recommendations for Immediate Action"
[264] "Deficiencies in Care at Nursing Homes and Racial/Ethnic Disparities Across Homes Fell 2006-11", Li, Y., et. al., Health Affairs, July 2015., "Racial Disparities in Nursing Facilities and How to Address Them"
[265] "Most Older Adults are Likely to Need and Use Long-Term Services and Supports Issue Brief", Johnson, R., et. al., Office of the Assistant Secretary for Planning and Evaluation (2021).
[266] "The National Imperative to Improve Nursing Home Quality"
[267] "Addition by Subtraction: Nursing Home Operators Mull Decertifying Beds to Stay Afloat", Skilled Nursing News (2021)., "Nursing Home Occupancy Woes Worse than Popularly Reported, Industry Expert Says", Mcknights Long-Term Care News (2021).
[268] Interviews with County staff.

Housing Cost Burden. Research suggests that increased access to affordable housing for older adults could reduce the rate of unnecessary nursing home admissions.[269] The U.S. Department of Housing and Urban Development (HUD) defines cost-burdened households as those who pay more than 30% of their income for housing costs.[270] Older adults are of special concern when looking at cost-burdened households as they are often on a fixed income and often have higher costs associated with health care and other necessities. It has been found that cost-burdened older adults often face tradeoffs between covering housing costs or paying for food, medications, and other health-related expenses.[271]

About one third of older adults in the United States are among cost-burdened households. The following groups of older adults are at even higher risk of being cost-burdened:

- Older adults who rent, because there are typically less protections against increasing housing costs for renters compared to homeowners;
- Older adults living in major metropolitan areas with a high cost of living; and
- BIPOC, and particularly Black households,[272] because historically, they have been systematically excluded from owning homes and building generational wealth through practices such as redlining and other policies that have led to residential segregation.[273]

Data from the National Health and Aging Trends Study shows that housing cost burdened older adults who rent are four times more likely to move to a nursing home compared to older homeowners who are not cost burdened.[274] Evidence shows that even if an older adult experiencing a housing cost burden is still able to function on their own and is healthy, they are still more likely to move to a nursing home.[275]

The Census Bureau data in the next table show the percentage of income that older adults in Montgomery County pay towards monthly housing costs for both renters and owners.

[269] "The Effects of Housing Cost Burden and Housing Tenure on Moves to a Nursing Home Among Low- and Moderate-Income Older Adults", Morales, M. and Robert, S., The Gerontological Society of America (2020).
[270] "Rental Burdens: Rethinking Affordability Measures", U.S. Department of Housing and Urban Development's Office of Policy Development and Research, Accessed Feb 3, 2023..
[271] "Mortgage Delinquency and Changes in Access to Health Resources and Depressive Symptoms in a Nationally Representative Cohort of Americans Older than 50 Years", Alley, D., et. al., American Journal of Public Health (2011).
[272] "Homeownership Among Older Adults: A Source of Stability or Stress?", Herbert, C. and Molinsky, J., American Society on Aging, Accessed Feb. 1, 2023.
[273] Ibid.
[274] "The Effects of Housing Cost Burden and Housing Tenure on Moves to a Nursing Home Among Low- and Moderate-Income Older Adults"
[275] Ibid.

Table 6-1. % of Household Income Spent on Monthly Housing Costs by Older Adults (County)

	% of County Older Adult Population
Owner-Occupied Housing Units	
<30% of Household Income	73.6%
>30% of Household Income	26.4%
Renter-Occupied Housing Units	
<30% of Household Income	42.7%
>30% of Household Income	57.3%

Source: 2021 American Community Survey (1-Year Estimates)

The data show that older adults in the County who rent are experiencing housing cost burden significantly more compared to older adults who own. Data collected by Montgomery County's Rental Assistance Program (RAP) and analyzed by OLO show a similar result:[276]

- Older adults (aged 65 and over) make up 50% of RAP clients, with 19% aged 65 – 74 and 31% aged 75 years and older.
- While race data is not disaggregated by age, BIPOC residents are disproportionately represented in the RAP program compared to the County's overall population.

The data in the next table show the breakdown of RAP clients by race and ethnicity compared to the overall County population.

Table 6-2. Race and Ethnicity of RAP Clients

Race and Ethnicity	RAP Clients, 2021 (%)	Montgomery County Residents, 2021 (%)
Black	42.26	17.10
White	24.72	49.54
Asian & Pacific Islander	10.25	13.50
Hispanic	10.25	16.85
Multiple Races	6.83	3.02
Unknown	5.69	N/A

Sources: Montgomery County Health and Human Services and 2021 U.S. Census Bureau[277]

[276] "Older Adults in Montgomery County Data Snapshot", Department of Health and Human Services, January 2022.
[277] "Older Adults in Montgomery County Data Snapshot"; "QuickFacts: Montgomery County, Maryland", United States Census Bureau, Accessed Feb. 12, 2023.

D. Financing the Cost of Nursing Home Care

Nursing home care in the U.S. is paid for by three payers: the federal-state Medicaid program, the federal Medicare program, and private payers.[278] Medicaid covers long-term stays at nursing homes for individuals who meet strict income and health-related eligibility requirements and is the primary payer of nursing home care, paying for the care of 62% of nursing home residents in 2020.[279] Medicare pays for most short-stay residents who are receiving rehabilitation or post-hospital acute care and paid for the care of just 12% of nursing home residents in 2019.[280]

Inadequate payments. Stakeholders generally agree that nursing homes make more money from Medicare patients than from Medicaid patients.[281] Though Medicare reimbursements cover a much smaller share of nursing home services, they account for almost a third of nursing home revenues.[282] Research finds the amount Medicare pays relative to the cost of treatment generates double digit profit margins for nursing facilities.[283] Conversely, many in the industry argue that Medicaid rates are too low to adequately cover the cost of providing comprehensive, high-quality care to residents. Moreover, nursing homes are not required to submit any evidence – data on costs, ownership, corporate structure, etc. – to allow regulators to evaluate whether rates are in fact adequate.[284] The inadequacy of Medicaid payments results in facilities cross subsidizing the lower Medicaid rates with the higher Medicare rates.

OLO spoke with County department representatives and nursing home industry advocates and there is consensus that Medicaid and Medicare reimbursement rates for nursing homes must be improved. Industry stakeholders explained that nursing homes in the County and the state struggle financially because 80% of their revenue – which comes from the government and is non-negotiable – is not enough to cover the cost of care.[285] Furthermore, stakeholders say stagnant Medicaid rates cannot sustain wage increases, particularly in marketplaces that demand wages higher than $15 an hour, like in Montgomery County.[286] A representative from Leading Age Maryland, a member organization for non-profit aging services organizations, described how some non-profit nursing homes in Maryland are using stop-gap strategies to help cover their costs such as raising funds through a foundation, or having residents donate money to fund staff bonuses.[287]

[278] "The National Imperative to Improve Nursing Home Quality"
[279] Ibid., pg. 357
[280] Ibid., pg. 53
[281] Ibid., pg. 519
[282] Ibid., pg. 359
[283] Ibid., pg. 359
[284] Ibid., pg. 521
[285] Interview with HFAM.
[286] Interview with LifeSpan Network.
[287] Interview with LeadingAge Maryland.

Inequities and unintended consequences. Research finds this disjointed financing system, with Medicare paying for short-term care, and Medicaid paying for long-term nursing home care, leads to several inequities and unintended consequences.[288]

- Studies find nursing homes that have a higher share of Medicaid patients have lower staffing ratios, receive more regulatory deficiencies, provide lower quality of care, and serve a higher proportion of people of color;[289]
- According to industry stakeholders, nursing home providers are often incentivized to take on more private pay residents to subsidize costs not covered by Medicaid payments;[290]
- Providers are encouraged to transfer people to hospitals rather than treating them in the nursing home because they can collect higher Medicare reimbursements from residents who return to the nursing home for post-acute care after a qualifying hospital stay, before transitioning those residents back to lower long-stay Medicaid rates;[291]
- Until 2019, Medicare's payment model weighted payments on the volume of medical services provided, resulting in some nursing homes improperly billing for unnecessary and excessive treatments. Medicare's new patient-driven payment model (PDPM) attempts to solve this problem by basing payments on the value of therapies instead. While it is too early to gauge the overall impact of the new payment model, initial research finds nursing homes may be responding to PDPM by reducing services and therapy staff.[292]
- Many individuals may receive inadequate care or go without care entirely because they can neither meet Medicaid's strict financial eligibility rules nor can they afford to pay out of pocket for extended nursing home care.[293]

Transparency and accountability of finances. Researchers agree that while the adequacy of Medicaid and Medicare rates must be reevaluated, an equally important need is to better understand how government funds are being spent by nursing homes. Namely, are tax-payer dollars going to the provision of services like staff wages and resident care? Or are funds being directed away from essential services to related-party organizations, who are also owned by the nursing home owner?

Researchers note that the annual cost reports nursing homes submit to CMS are insufficient to understanding the actual cost of providing care and services.[294] Analysts argue that the only way to see a nursing home's true expenses is to see the combined payouts to its "related parties" – ancillary businesses like real estate, insurance, and/or therapy and management services that the nursing home

[288] "The National Imperative to Improve Nursing Home Quality"
[289] Ibid.; "Disparities in Long-Term Care: Building Equity into Market-based Reforms", Konetzka, R. and Werner R., Med Care Res Review (2009). ; "Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care", Mor, V., et. al., The Milbank Quarterly (2004).
[290] Interview with Leading Age Maryland.
[291] "The National Imperative to Improve Nursing Home Quality"
[292] Ibid.
[293] Ibid.
[294] Ibid.

owns and controls but buys goods and services from.[295] This information is only accessible through a facility's consolidated, audited financials, which it does not submit to CMS.[296]

Researchers contend that a lack of financial oversight and accountability from federal and state regulators has resulted in egregious cases of nursing homes, often for-profit facilities, intentionally providing inadequate care to cut costs and boost profits. In December 2022, New York Attorney General Letitia James filed a lawsuit against the owners, related parties, and operators of Fulton Commons Care Center, Inc. in New York, alleging the nursing home fraudulently took over $16 million in Medicaid funds to enrich themselves, resulting in insufficient staffing and widespread neglect and abuse of residents.[297] Earlier that year, the residents of Alden nursing homes in Illinois filed a similar lawsuit against the home's operators. The suit claims the large, for-profit nursing facility network, which has more than $250 million in annual revenue, profited from "systematically and knowingly understaffing the Alden Facilities, causing dangerous, distressing, and grossly unsanitary living conditions for thousands of residents."[298]

E. Private Equity Investment in Nursing Homes

Since the 2000s, private equity (PE) firms have increasingly invested in healthcare facilities, including nursing homes. Data show that as of 2022, PE firms own approximately 5-11% of nursing homes in the United States.[299] While supporters of PE investment in healthcare assert that PE firms improve the performance of the companies they acquire and provide a way for healthcare companies to obtain capital, federal government research and data point to many problems associated with the quality of care in PE-owned facilities.[300] Research by the Medicare Payment Advisory Commission, an independent congressional agency that advises Congress on Medicare issues, found that purchases of nursing homes by PE firms are associated with higher patient mortality rates, fewer staff, higher management fees, and an overall decline in patient well-being.[301]

[295] "Require Full Disclosure and Accountability for Nursing Home Reimbursement", Center for Medicare Advocacy (2023).
[296] Tosh, E., "A Minimum Staffing Standard and Financial Transparency: The Keys to Better Care for Nursing Home Residents," National Consumer Voice for Quality Long-Term Care 46th Annual Conference, November 16, 2022.
[297] "Attorney General James Sues Long Island Nursing Home for Repeated Financial Fraud and Resident Neglect", New York State Attorney General (2022).
[298] "Lawsuit Alleges Alden Nursing Homes Provided Inadequate Staff and Care, Leading to Injuries and Illness. Company Denies Allegations", Chicago Tribune (2022).
[299] "Private Equity Ownership of Nursing Homes Triggers Capitol Hill Questions - And a GAO Probe", KFF Health News (2022).
[300] "Report to the Congress: Medicare and the Health Care Delivery System", Medicare Payment Advisory Commission (2021).
[301] "A Primer on Private Equity at Work: Management, Employment, and Sustainability", Appelbaum, E. and Batt, R., Center for Economic and Policy Research (2012).; "Report to the Congress: Medicare and the Health Care Delivery System"

1. What is Private Equity?

Private equity (PE) firms raise investment funds primarily from institutional investors (i.e., pension funds, endowments, insurance companies) in addition to wealthy individual investors. These limited partner (LP) investors account for the majority of the capital in the fund while PE partners who manage the fund (general partners) provide a smaller share of capital. PE assets are not publicly traded and not available on the public stock market or through bond exchanges. PE partners typically promise returns to investors substantially above the stock market.[302]

Economic research shows PE firms generally make money by replacing a significant percentage of the original value of the purchased company's equity with debt. The debt requires the company to cut costs in order to pay the interest on the debt or pay down the debt. Firms often cut costs by reducing staffing levels, wages, and benefits and close less profitable units in order to maximize profits.[303] PE firms then make money off the debt by requiring the acquired company to pay the PE firm for transaction and monitoring fees. This is problematic as PE firms own the company, can sit on the board, and can approve monitoring fees, so they are able to essentially pay themselves.

According to a report given to Congress by the Medicare Payment Advisory Committee, PE firms use the following common strategies to make nursing home facilities more profitable:

- Increasing revenues through actions such as providing more services, shifting towards a higher Medicare compensated mix of services and procedures, and raising prices where possible;
- Reducing costs through actions such as lowering labor costs, eliminating auxiliary services like transportation, and taking advantage of economies of scale through the acquisition of multiple facilities; and
- Selling off the real estate of nursing home facilities.[304]

PE investment in the U.S. health care sector has increased from less than $5 billion in 2000 to more than $100 billion in 2018.[305]

It is important to note that while all PE nursing home facilities are for profit, not every for-profit nursing home facility is owned by a PE firm. PE firms are a subset of for-profit nursing homes, which account for about 70% of all nursing homes in the U.S.[306]

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[302] Ibid.

[303] "Private Equity and Public Problems in a Financialized World: An Interview with Rosemary Batt", Morgan, J., Real-World Economic Review (2020).

[304] "Report to the Congress: Medicare and the Health Care Delivery System"

[305] "Private Equity Buyouts in Healthcare: Who Wins, Who Loses?", Appelbaum, E. and Batt, R., Center for Economic and Policy Research (2020).

[306] "Report to the Congress: Medicare and the Health Care Delivery System"

2. Private Equity Acquisitions of Nursing Homes – Impacts on Quality of Care

There has been research conducted on how PE acquisition of nursing homes impacts quality of care – from services to staffing to health outcomes, and some findings suggest that health outcomes in PE-owned facilities are worse compared to facilities under other ownership.[307] A report from The Government Accountability Office (GAO) found that PE-owned nursing homes had higher rates of quality of care deficiencies compared to non-profit facilities and lower staffing levels compared to both for-profit and non-profit nursing homes.[308] *The Washington Post* reported in 2020 that the Portopiccolo Group, a well-known PE firm, had a record of poor safety inspections, including infection-control lapses and shortages of staff.[309] The group began purchasing nursing homes in 2016 and during the pandemic, purchased at least 22 facilities, with eight located in Maryland.[310]

Short Term Mortality. A 2021 study from the National Bureau of Economic Research found that PE-owned facilities increased Medicare residents chance of short-term mortality by 10%, compared to a non-PE firm owned facility.[311] A key measure of patient welfare is short-term welfare and it was found that older patients, especially those with relatively low disease burdens, (I.e., lower maintenance patients) were especially impacted by the increase in chance of short-term mortality.[312] In a report to congress by the Medicare Payment Advisory Commission, they associated elevated antipsychotic drug use in PE-owned facilities with a decline in hours of nurses and staff.[313]

Changes in Quality of Care. Research shows the quality of care tends to decline under PE-owned nursing homes, with these homes performing below average in two key metrics of well-being: a greater decline in mobility and an increase in levels of pain.[314] Further, studies show a higher rate of hospitalization among residents in PE-owned nursing homes, which is often an indicator of poor quality long-term care. One study found an 11% increase in emergency hospital visits and a 9% increase in hospitalizations, compared to residents in other for-profit nursing homes.[315]

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[307] "Private Equity Ownership of Nursing Homes Triggers Capitol Hill Questions - And a GAO Probe", Kaiser Health News (2022).; It should be noted that there are mixed findings on the impact of PE in quality of care and health services, as outcomes vary with strategies that PE owner's employ.

[308] "Nursing Homes: Private Investment Homes Sometimes Differed from Others in Deficiencies, Staffing , and Financial Performance", Government Accountability Office (2011).

[309] "An Investment Firm Snapped up Nursing Homes During the Pandemic. Employees Say Care Suffered.", Washington Post (2020).

[310] Ibid.

[311] "Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes", Gupta, A., et. al., National Bureau of Economic Research (2021).

[312] Disease burden can be defined as the impact of a health problem as measured by financial cost, mortality, morbidity, or other indicators.

[313] "Report to the Congress: Medicare and the Health Care Delivery System"

[314] "How Patients Fare When Private Equity Funds Acquire Nursing Homes"

[315] "Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents", Braun, R., et. al., JAMA Health Forum (2021).

Changes in Costs. In addition, PE ownership on average translates to higher charges for patients. The overall bill is more than 10% higher if a patient goes to a PE-owned nursing home compared to non-PE-owned one.[316] Further, two studies from 2021 found that in PE-owned nursing homes, Medicare costs per resident were higher.[317]

Changes in Staffing Levels. Usually, PE-owned nursing homes reduce staffing levels and services to cut costs and maximize profits.[318] This has a direct impact on the quality of care as staffing levels are the greatest indicator of quality of care in nursing homes. For example, higher nursing staff hours are associated with better resident care quality as there are fewer pressure ulcers, improved resident independence in daily activities, less unhealthy weight loss and dehydration, less improper use of antipsychotics, and lower mortality rates.[319]

Antipsychotic Medication Usage. Residents of PE-owned nursing homes are 50% more likely to be placed on antipsychotic medication. According to an article from the National Bureau of Economic Research, this practice is likely to reduce staffing needs, as sedated patients need less individualized attention, such as behavioral therapy.[320]

3. Oversight of Private Equity Investment in Nursing Homes

Since the 1970s, CMS has been required to collect ownership data on any nursing home participating in Medicare and/or Medicaid.[321] However, ownership data submitted to CMS is often incomplete and sometimes inaccurate. PE firms generally have complex corporate structures, which are not always reflected in CMS ownership data. For example, CMS typically does not indicate relationships like a parent organization or legal entities that are also owned by the parent organization. This has led to less transparency in the ownership of nursing homes.[322]

Information from the federal government suggests that PE firms are turning towards other investments in long-term care, such as home health care. As more U.S. seniors prefer to age in place, PE investment is increasing in hospices and home health care.[323] The Biden-Harris Administration has proposed efforts to strengthen data collection, including more robust reporting of corporate ownership of nursing home facilities and better tracking of previous violations of owners and

[316] "How Patients Fare When Private Equity Funds Acquire Nursing Homes"
[317] "Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents", "Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes"
[318] "Association of Private Equity Investment in US Nursing Homes With the Quality and Cost of Care for Long-Stay Residents"
[319] "Appropriate Nurse Staffing Levels for U.S. Nursing Homes"
[320] "How Patients Fare When Private Equity Funds Acquire Nursing Homes"
[321] "Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data", Government Accountability Office (2010).
[322] "Report to the Congress: Medicare and the Health Care Delivery System"
[323] Ibid.

operators.[324] Reports, however, also show that CMS and state health agencies do not currently have the capacity to provide adequate oversight.[325]

4. Private Equity-Owned Nursing Homes in Maryland and Montgomery County

PE firms have invested in Maryland-based nursing homes. A 2020 *Washington Post* article identified eight nursing home facilities purchased in Maryland by Portopiccolo Group during the first year of the COVID-19 pandemic. Two of the nursing homes identified in the article are in Montgomery County: Peak Healthcare Facility at Sligo Creek in Takoma Park, MD and Fox Chase Rehabilitation Center in Silver Spring, MD. [326]

While ownership data reported to CMS is often incomplete and does not include information on links to parent companies and investors such as Portopiccolo, researchers have identified at least five operators that run Portopiccolo nursing homes: Peak Healthcare, Accordius Health, Pelican Health, Orchid Cove, and Clearview Health Management.[327] Another PE firm that invests in nursing homes and nursing home operators, Tryko Holdings, LLC, has a 5% or greater indirect ownership interest in Collingswood Rehabilitation and Healthcare Center in Rockville, MD.[328]

[324] "Fact Sheet: Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes"
[325] "The National Imperative to Improve Nursing Home Quality"
[326] "An Investment Firm Snapped up Nursing Homes During the Pandemic. Employees say Care Suffered"
[327] "Pulling Back the Veil on Today's Private Equity Ownership of Nursing Homes", O'Grady, E., Private Equity Stakeholder Project (2021).
[328] CMS ownership data, Accessed Mar. 20, 2023.

Chapter 7. Findings

This OLO report responds to the Council's interest in understanding the universe of nursing homes in Montgomery County, including how state and local laws impact how nursing homes in the County are run, and how the Council can better support nursing homes and their residents.

This section summarizes OLO's findings, organized into the following themes:

- Regulations and Enforcement;
- Nursing Home Quality and Resident Outcomes;
- Nursing Home Workforce;
- Nursing Home Financing and Ownership; and
- Supports for Nursing Home Residents and Older Adults in the County.

Regulations and Enforcement

Finding #1. The County has little oversight and enforcement authority over nursing homes. Federal and state regulations comprise the bulk of the regulatory framework for nursing homes, with enforcement and oversight responsibilities generally split between federal and state agencies.

Federal regulations set minimum standards that all nursing homes must follow and states are permitted to set and enforce stricter and/or stronger standards. All nursing homes in Montgomery County that are Medicare and/or Medicaid certified must follow these standards.

As the County Board of Health, the County Council has the authority to adopt and enforce any needed standards and regulations for the health, safety, welfare, and physical requirements of the patients in institutions, but only if the adopted rules and regulations do not conflict with any Maryland State Board of Health rules and regulations.

Long-term care facilities must have a state license issued by the Maryland Department of Health to operate. Montgomery County also requires a County nursing home license in addition to the state license. However, state-licensed facilities can operate without the County license. Facilities generally use the County license to renew their insurance.

Finding #2. The federal requirements for participation in Medicare and Medicaid serve as the primary form of regulation for nursing homes as most nursing homes are Medicare- or Medicaid-certified. States help determine nursing homes' compliance with federal requirements through facility surveys and inspections. Funding and staff shortages have caused inspections to fall behind in many states, including in Maryland.

The Nursing Home Reform Act of 1987 established federal requirements that nursing homes must meet to participate in Medicare and Medicaid programs. Because Medicare and Medicaid are the principal purchasers of long-term care in this country, most nursing homes are Medicare- or Medicaid-certified and subject to federal regulations. Enforcement of federal regulations is ultimately the responsibility of CMS, but states help determine compliance by conducting facility surveys and inspections and by reporting their findings and recommendations to CMS.

The Maryland Department of Health's Office of Health Care Quality (OHCQ) is the state enforcement agency for federal and state nursing home regulations. OHCQ conducts annual state surveys and inspections, reports deficiencies, and issues state licensing for Medicare and/or Medicaid certified nursing homes in Maryland.

Federal funding to conduct these inspections has remained flat over the past seven years and inspections have fallen behind in many states. According to data gathered by the U.S. Department of Health and Human Services' Office of Inspector General, as of May 2023, 80% of nursing homes in Maryland have gone at least 16 months without a standard survey. Staff in Montgomery County departments have expressed concerns that staff shortages at OHCQ have impacted state oversight of nursing homes in the County.

Finding #3. Prior to 2021, County surveyors conducted inspections of nursing homes in Montgomery County on behalf of the state. The State of Maryland terminated its Memorandum of Understanding with the County for this work as of July 1, 2021, and OHCQ has absorbed the work previously done by the County survey team.

A long-standing Memorandum of Understanding (MOU) between the Maryland Department of Health and Montgomery County allowed for County surveyors to conduct certifications, surveys, and complaint investigations for the 34 nursing homes in the County on behalf of the state. When the state terminated the MOU in 2021, five and a half state surveyors absorbed the work previously done by eight to 10 County surveyors.

Over the course of 2021 and into 2022, County departments grew concerned that state enforcement efforts in Montgomery County were lagging due in part to staff shortages at OHCQ. Separate attempts were made by the Montgomery County Commission on Aging, the County Long-Term Care Ombudsman, and Maryland State Delegate Kirill Reznik to seek information from OHCQ on how many nursing home inspections occurred in Montgomery County since July 1, 2021.

In October 2022, OHCQ responded, explaining its plans to increase its survey staff by 10 new positions in FY22 and FY23. The following month it specified that it conducted 172 surveys (consisting of annual surveys, complaint surveys, and inspection surveys) at 33 nursing homes in the County between July 1, 2021 and September 14, 2022. OLO was unable to speak with OHCQ representatives about the status of the new positions.

Finding #4. The COVID-19 pandemic had a devastating and disproportionate impact on nursing homes in the United States. Accordingly, the federal and state governments are taking actions to improve nursing home quality of care and to undertake research on best practices for addressing the long-standing challenges facing nursing homes, nursing home residents, and their families.

In 2022, President Biden announced new actions to improve nursing home quality, including more aggressive enforcement for the worst-performing facilities, more resources to support better paying nursing home jobs, and preventing abuse and Medicare fraud by nursing home owners. The Administration also proposed establishing a new federal minimum staffing standard for nursing homes by 2023.

At the state level, Maryland Governor Wes Moore has expressed support for older adult residents' ability to age comfortably and with dignity. The state has proposed actions that include leveraging general dollars to ensure better oversight and compliance and addressing staff shortages in long-term care facilities. The Maryland General Assembly has also introduced and enacted bills aimed at improving the quality of care in nursing homes. Senate Bill (SB) 468, which took effect on June 1, 2023, is aimed at increasing compensation for nursing home care workers. It will increase the Medicaid reimbursement rate for long-term care providers with the requirement that providers pass on 90% of the increase directly to care workers' wages.

In 2022, the National Academies of Sciences, Engineering, and Medicine released *The National Imperative to Improving Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff*, an extensive study that examines how the United States delivers, finances, regulates, and measures the quality of nursing home care. The study outlines best practices for tackling the long-standing issues facing nursing homes, nursing home residents, and their families.

Nursing Home Quality and Resident Outcomes

Finding #5. Montgomery County has 34 nursing homes, 11 of which are owned by nonprofit organizations and 23 that are owned by for-profit companies. Research finds that for-profit nursing homes are associated with lower quality of care and poorer resident outcomes.

Over 70% of nursing homes in the United States are owned by for-profit companies, most of which are part of corporate-owned chains where one parent company owns two or more facilities. However, recent research shows that large national nursing home chains are increasingly being replaced by smaller, regional, PE-owned facilities.

Research and data show that for-profit nursing homes, and in particular PE-owned facilities, provide lower quality of care compared to non-profit facilities when measured across variables such as: (1) staff-to-resident ratios; (2) the use of physical restraints on patients; (3) residents with pressure ulcers; and (4) deficiencies cited by regulators. National data on nursing homes' CMS ratings also show that for-profit nursing homes tend to have lower ratings compared to non-profit nursing homes.

The following table summarizes the overall CMS ratings for the 34 nursing homes in Montgomery County by ownership type:

Table 7.1 Federal CMS Ratings and Ownership Type for Nursing Homes in Montgomery County

Overall Rating	Total # of nursing homes	For-profit #	Non-profit #
4 or 5	18	9	9
3	6	5	1
2	5	4	1
1	5	5	0
Total	**34**	**23**	**11**

Finding #6. Decades of research data show that Black nursing home residents receive lower-quality care and experience worse health outcomes when compared to White residents. The COVID-19 pandemic, which disproportionately impacted Black nursing home residents, brought these racial disparities to the forefront.

Decades of systemic racism and discriminatory laws and practices in the United States have negatively impacted where and how communities of color, particularly Black communities, live, work, go to school, and access health care. These social determinants of health have been key drivers of poor health outcomes consistently seen in communities of color. Data show that health disparities accumulate over the course of a lifetime and create inequities in patient outcomes in nursing homes.

Further, because of discriminatory laws and practices that have caused racial wealth gaps, Black, Indigenous, and other people of color (BIPOC) older adults are also more likely to rely on Medicaid to pay for their long-term care and are about 2.5 times more likely than White nursing home residents to live in nursing homes that primarily serve individuals that rely on Medicaid. Research shows that facilities that predominantly serve Medicaid residents, a category Black and Latino residents are more likely to fall in to, are more likely to receive lower ratings, have fewer staff, and experience challenges with federal and state regulatory compliance.

Numerous studies show that Black nursing home residents receive lower-quality care and experience worse health outcomes than White residents. For example, when compared to White residents, Black nursing home residents are more likely to be physically restrained; more likely to develop severe pressure ulcers; more likely to be hospitalized for conditions associated with not receiving proper care (e.g., poor nutrition, dehydration, bedsores, etc.); treated for pain less often; vaccinated less often; and more likely to report lower quality of life.

The COVID-19 pandemic, which disproportionately impacted Black nursing home residents, illuminated these preexisting racial health disparities. Studies have found that nursing homes with the lowest percent of White residents were more than twice as likely to have COVID-19 cases or deaths as those with the highest percent White residents.

Finding #7. The Centers for Medicare and Medicaid Services rate all Medicare- and Medicaid-certified nursing homes on a Five-Star Quality Rating System. The five-star ratings are intended to give consumers a user-friendly way to evaluate nursing home quality but CMS also uses the ratings as a regulatory tool to enforce federal nursing home quality standards.

CMS began publishing public ratings for nursing homes in 1998 and the current Five-Star Quality Rating System was rolled out in 2008. The system evaluates nursing home quality on measures taken from state health inspections and self-reported staffing and quality of care data. CMS also uses ratings to ensure nursing homes meet federal quality standards to participate in Medicare and Medicaid programs. Nursing homes that receive low ratings due to deficiencies can incur fines and penalties.

Nursing homes are rated between 1 (the lowest score) and 5 (the highest score) stars and CMS publishes star ratings on its Nursing Home Compare website. Over one-third of Medicare- or Medicaid-certified nursing homes have overall 1- or 2-star ratings and 39% of all nursing home residents reside in these nursing homes. Stakeholders who spoke with OLO suggest residents and families of residents rarely use the CMS quality of care ratings to select a nursing home, basing decisions instead on bed availability, insurance, and the proximity of the facility to family and friends.

Finding #8. Some data that contribute to CMS' star rating are self-reported by nursing homes. Research shows CMS does not adequately oversee or audit collection of these data, often resulting in incorrect and inflated staffing and quality of care information.

Critics of the effectiveness and validity of the CMS Five-Star Quality Ratings note that ratings tend to be higher for measures that are self-reported by nursing homes (i.e., quality measures and staffing levels) than for measures based on data from state health inspections. Studies show that self-reported data by nursing homes often results in incorrect and inflated numbers, resulting in nursing homes receiving star ratings that may not reflect the true quality of care they provide.

Studies show, for example, that nursing facilities do not always report incidents of potential abuse and neglect to state survey agencies and nursing homes are incentivized to inflate numbers such as their staff to patient ratios because higher star ratings are linked to higher profitability.

Nursing Home Workforce

Finding #9. The number one challenge facing nursing homes in Montgomery County is the healthcare workforce crisis, which has been exacerbated by the COVID-19 pandemic. A shortage of healthcare professionals has impacted the nursing home industry at all levels – from nurses to nurse surveyors to professors of nursing.

The health care staffing shortage is one of the biggest public health crises currently facing the United States. In Maryland, one in every four hospital nursing positions is vacant and over two-thirds of nurses who were surveyed said they have considered quitting the profession because they feel overworked, burned out, and underappreciated.

Stakeholders report that the workforce shortage, which has been exacerbated by the COVID-19 pandemic, is also the number one challenge facing nursing homes in Montgomery County. Factors contributing to nurse shortages include increased workloads (leading to higher levels of stress and burnout and resulting in staff turnover) and poor pay and benefits (leading many nurses and nursing assistants to leave the profession entirely). The pipeline of new nurses in the County is also being impacted by a shortage of nursing faculty, due in part to a spate of retirements and of nursing graduates choosing to take higher-paying clinical and private-sector jobs instead of becoming educators.

Research data also show that state regulatory agencies often do not offer nurse surveyors competitive salaries, resulting in weaker enforcement of federal regulations and higher instances of quality-of-care issues in nursing homes.

Finding #10. Inadequate staffing is a persistent problem in nursing homes despite decades of research showing higher staffing levels are associated with better health and quality of life outcomes for residents.

Currently, there is no federal requirement for a minimum staffing standard in nursing homes. CMS recommends facilities provide a daily minimum of 4.1 hours of total direct nursing care per resident to maintain quality of care.

Many states have developed their own nursing home staffing minimums, but none meets CMS's recommended minimum, except for the District of Columbia (requiring 4.16 total nursing care hours per resident per day). Maryland requires a minimum of 3 hours of total nursing care per resident per day in nursing homes.

Inadequate staffing can lead to dire consequences for nursing home residents. Studies find residents in understaffed facilities are often unable to get assistance with toileting and personal care and are more likely to be inappropriately drugged, leading to significant harm and sometimes death. Researchers and stakeholders assert that the government has not prioritized enforcing existing rules and expectations for nursing home staffing. Regulators rarely cite or sanction nursing homes for staffing deficiencies despite many studies showing nursing homes in the United States regularly understaff their facilities.

Finding #11. Data show that nursing homes experience high rates of staff turnover due to exceedingly high workloads, poor management, lack of training, and poor compensation and benefits. These factors disproportionately impact women of color and immigrants, who make up most of the nursing home workforce.

CMS data reveals the average nursing home in the country replaces 52% of its direct care nursing staff every year. In the average nursing home in Montgomery County, 47% of nursing staff are employed for less than two years. Research shows that nursing home staff choose to leave their jobs because of poor working conditions like low pay with few benefits, little to no professional development or training opportunities, bad management, and overwhelming patient caseloads.

Stakeholders report that low pay is a critical reason why nursing homes in Montgomery County and across Maryland have trouble attracting and retaining nursing staff. The median annual salary for a Geriatric Nursing Assistant (GNA) in a nursing home in the County is $34,026. Nursing workers can make more money working in hospitals or as independent travel nurses. A registered nurse (RN) working in a hospital emergency room in Montgomery County makes 12% more than a RN working in a nursing home.

In Maryland, these challenging working conditions disproportionately impact women of color and immigrants, who make up most of Maryland's nursing home workforce. Ninety-five percent of nursing

home direct care staff in Maryland are women, nearly 80% are people of color, and 31% are either naturalized U.S. citizens or citizens of another country.

Finding #12. Maryland is one of the only states that requires nursing home workers to get a Geriatric Nursing Assistant (GNA) certification. Stakeholders say this additional requirement is a barrier to increasing the number of nursing assistants working in nursing homes in the County.

The Maryland Board of Nursing certifies all nursing assistants in the state. In addition to the basic Certified Nursing Assistant (CNA) certification, all nursing assistants who work in licensed comprehensive care facilities (i.e., nursing homes) must also pass the state's Geriatric Nursing Assistant (GNA) examination, which requires an additional 75-hour training program. The GNA exam has a nearly four-month testing backlog.

Nursing home industry stakeholders argue for the elimination of the GNA certification requirement because it discourages CNAs from entering Maryland's nursing home workforce and is not known to be required in any other state. Instead of waiting for GNA certification, CNAs are choosing to work in home care, assisted living communities, or hospitals, often for more competitive wages than in nursing homes. Stakeholders argue this barrier places nursing homes in Maryland at a competitive disadvantage for attracting desperately needed staff.

Nursing Home Financing and Ownership

Finding #13. Stakeholders agree that Medicaid reimbursement rates do not adequately cover the cost of nursing home services, resulting in inequities and unintended consequences for resident care. However, more transparency and oversight into how nursing homes spend government funds is also critically needed.

Stakeholders assert that Medicaid rates are too low to adequately cover the cost of providing comprehensive, high-quality care to nursing home residents. For example, local stakeholders say nursing homes in the County and across Maryland struggle financially because 80% of their revenues come from non-negotiable Medicaid reimbursements.

At the same time, research data show the amount that Medicare pays relative to the cost of care generates double digit profit margins for nursing facilities. This financing system results in inequities and unintended consequences, such as facilities that serve higher shares of Medicaid patients – who are disproportionately people of color – cutting costs by reducing resident to staff ratios, resulting in lower quality of care.

Researchers also assert a need for transparent data on nursing home ownership and data on how facilities spend government funds. Detailed data on nursing home expenses is only accessible through consolidated, audited financial statements, which are not required to be disclosed by CMS.

Ownership data that does exist on Medicare and/or Medicaid certified nursing homes is self-reported by facilities and often incomplete and sometimes inaccurate. Further, CMS data typically does not indicate relationships between corporations and/or legal entities operating within the nursing home.

Poor financial oversight and accountability from federal and state regulators has resulted in high-profile lawsuits involving nursing homes allegedly providing inadequate care to cut costs and boost profits. For example, the New York Attorney General filed a lawsuit in 2022 against Fulton Commons Care Center, Inc. in New York, alleging the nursing home fraudulently directed $16 million in Medicaid funds to a shell company and to the owner's children, resulting in insufficient staffing and widespread resident neglect and abuse.

Finding #14. Since the 2000s, private equity (PE) firms have increasingly invested in nursing homes, employing various strategies to lower costs and make nursing homes more profitable. Research shows that health outcomes in PE-owned facilities are worse compared to facilities under other ownership.

Estimates show that PE firms owned five to 11% of nursing homes in the United States in 2022. PE firms raise investment funds primarily from institutional investors (i.e., pension funds, endowments, insurance companies) and wealthy individual investors, who often are promised financial returns substantially above the stock market. To make money, PE firms often take on debt which they pay down by cutting costs like wages and benefits.

A report given to Congress by the Medicare Payment Advisory Committee states that PE firms employ these common strategies to make nursing home facilities more profitable:

- Increasing revenues by providing more services, shifting towards a higher Medicare compensated mix of services and procedures, and raising prices where possible;
- Reducing costs through lowering labor costs, eliminating auxiliary services like transportation, and taking advantage of economies of scale through the acquisition of multiple facilities; and
- Selling off the real estate of nursing home facilities.

Data show that PE-owned nursing homes are associated with higher patient mortality rates, fewer staff, higher management fees, and an overall decline in patient well-being. A report from the federal Government Accountability Office (GAO) found that PE-owned nursing homes had higher rates of quality-of-care deficiencies compared to non-profit facilities and lower staffing levels compared to both for-profit and non-profit nursing homes.

The Portopiccolo group, a PE firm, began purchasing nursing homes in 2016 and purchased at least 22 facilities nationwide during the pandemic, including eight in Maryland. Data show that The Portopiccolo Group has a record of poor safety inspections, including infection-control lapses and shortages of staff. The Washington Post identified two nursing homes in Montgomery County owned by PE firms and OLO research revealed a possible third one.

Supports for Nursing Home Residents and Older Adults in the County

Finding #15. The Montgomery County Long-Term Care (LTC) Ombudsman is a federally mandated program with responsibility for helping resolve individual complaints, addressing systemic issues, and advocating on behalf of residents in Montgomery County nursing homes. National studies find LTC Ombudsman programs, while often underfunded by governments, show positive impacts for nursing home residents.

The County LTC Ombudsman is an independent program located in the Department of Health and Human Services' Aging and Disability Services division and has operated since 1977. By law, the County LTC Ombudsman is neither a regulatory nor enforcement entity. Instead, County LTC Ombudsmen work as mediators and liaisons between residents, their families, facility staff, and government agencies to ensure residents receive the care they are entitled to. Ombudsmen visit nursing homes in the County and meet with residents in person to observe living conditions and hear concerns. They also educate residents and facility staff on policies and regulations and resident rights and they provide referrals to other state and County agencies.

While the program serves residents living in all 34 nursing homes and in the more than 200 assisted living facilities in the County, DHHS reports most of the Ombudsman's services go toward helping assisted living residents. The County government fund and provides human resource services for some of the program's personnel.

National studies of LTC Ombudsman programs find they may help prevent negative outcomes for nursing home residents because ombudsmen are able to bring more quality issues to the attention of state regulators. Research finds the effectiveness of LTC Ombudsman programs significantly increases when they receive more funding, more paid staff, and have smaller resident caseloads.

Finding #16. The COVID-19 pandemic has significantly impacted the County LTC Ombudsman's operations. Staff and volunteer shortages are making it difficult to conduct regular in-person visits to long-term care facilities in the County. Prior to the pandemic, the program had close to 50 volunteers; today it is operating with just eight active and four inactive volunteers.

County LTC Ombudsman program services are provided by staff and volunteers who are certified and designated by the state and County as LTC Ombudsman representatives. Before the pandemic, program volunteers logged about 10,000 visitation hours a year with residents. Volunteers would visit nursing homes at least weekly, and staff would visit at least monthly. Once the pandemic began, most of the program's volunteers, who are 70 years or older, stopped volunteering because of the high health risk of visiting long-term care facilities.

County LTC Ombudsman operations continued throughout the height of the pandemic, but staff and volunteers conducted most of their facility visits virtually or by phone. The County LTC Ombudsman program resumed in-person visits on a limited, as needed basis at the end of the 2021 federal reporting year, but staff and volunteer shortages are making it difficult to visit more often than quarterly, the federally mandated minimum. Staff report remote appointments are resulting in fewer resident complaints, and more residents experiencing isolation.

Data in the table on the next page reflect the significant impact that COVID-19 had on the County LTC Ombudsman program between Federal Fiscal Year 2019 and Federal Fiscal Year 2022.

Table 7.2 Montgomery County LTC Ombudsman Program Statistics, FFY19 - FFY22*

Program Function	FFY19	FFY20	FFY21	FFY22
Complaints Closed	454 Total 303 Nursing Homes 103 Assisted Living	210 Total 194 Nursing Homes 16 Assisted Living	219 Total 189 Nursing Homes 30 Assisted Living	180 Total 150 Nursing Homes 30 Assisted Living
Facility Consultations/Facility Staff Information & Assistance	558	2,253	846	507
Information & Assistance to Individuals	1,529	1,503	2,046	999
Facility Visits Completed by Ombudsmen	3,218	1,053 (6 visits by exception between 3/16/20 – 12/03/20)	171	884
Time Donated by Certified/Designated Volunteers	5,215 Hrs.	2,072 Hrs.	1,185 Hrs.	856 Hrs.

Source: Long-Term Care Ombudsman Program presentation to Montgomery County Council Health and Human Services Committee, December 3, 2020; County LTC Ombudsman program

*The LTC Ombudsman program operates and reports in a Federal Fiscal Year (FFY) cycle from October – September.

Finding #17. In Montgomery County, 32 out of 34 nursing homes have either a resident or a family council. Before 2021, the County LTC Ombudsman would connect resident and family councils directly with local government surveyors to better share resident concerns, but this process has broken down since the state Office of Health Care Quality (OHCQ) took over all facility survey and inspection responsibilities.

Federal and state law allows nursing home residents and family members to have a direct say in improving the quality of care and operations of their nursing home by participating in resident or family councils. Nursing homes are legally required to provide councils with private meeting spaces, designate a member of staff to assist with council requests, and respond to councils' concerns and recommendations regarding resident care and quality of life.

In Montgomery County, 32 out of the 34 nursing homes have either a resident or a family council. The County LTC Ombudsman supports these councils in preparing for meetings, providing resources and strategies, and ensuring councils receive adequate answers from facility staff.

Until 2021, inspections of nursing homes in Montgomery County were conducted by a staff of eight to 10 County surveyors employed in the County Department of Health and Human Services on behalf of the state. The State Maryland ended the partnership in 2021 and took over nursing home inspection responsibilities. Before 2021, County LTC Ombudsmen would serve as liaisons between resident and family council members and local surveyors to bring resident concerns to the attention of regulators. County staff report that this process broke down once the state took over all survey responsibilities for nursing homes in the County.

Finding #18. There are gaps in services in the County for nursing home residents. Specifically, nursing home residents in the County may be excluded from County programs due in part to an assumption that they receive services through their respective facilities.

OLO was informed by staff from the Department of Health and Human Services that gaps in services exist for nursing home residents in the County, including gaps in transportation, mental health services, and religious services. County staff shared concerns that older adults in nursing homes are often left out of programs and activities the County provides for older adults, due in part to an assumption that nursing home residents receive services through their respective facilities. However, County staff believe there are nursing home residents not receiving services they could greatly benefit from.

Staff from the County's African American Health Program (AAHP), which often connects Black older adults in the community with resources and supports, reported they do not have enough information about access to available County resources for nursing homes residents and desire better communication with County departments in order to assist residents in long-term care and their families. AAHP staff also noted difficulty in gaining access to nursing homes because for-profit nursing homes have no obligation to allow outside organizations inside their facilities to provide services.

Finding #19. Many older Black residents in long-term care facilities in the County feel they do not have the same access to County programs as White residents do, nor do they feel they receive culturally appropriate services and care.

Staff from the County's African American Health Program observed that many older Black residents in the County feel they do not have the same access to County programs as White residents because programs are often targeted to White individuals. Staff cite as an example the County frequently offers programming in retirement communities like Leisure World but few Black seniors in the County cannot afford to live in these retirement communities and are, therefore, left out of senior programs.

AAHP staff also described a need for more cultural competence within County programs that serve older adults. Cultural competence refers to an organization and its employees' knowledge and awareness of an individual's beliefs, race, and values to provide that individual culturally appropriate services. For example, older BIPOC adults seeking County services, such as services for aging in place

and home-based care, often feel more comfortable navigating these complex resources with someone of their own race and/or ethnicity.

Finding #20. Studies show that older adult renters who are housing cost burdened are four times more likely to move to a nursing home compared to older homeowners who are not cost burdened.

About one third of older adults (those age 65 or older) in the United States are housing cost burdened, meaning they spend more than 30% of their household income on housing. The following groups of older adults are at especially high risk of being housing cost burdened:

- Older adults who rent because there are typically less protections against increasing housing costs for renters compared to homeowners;
- Older adults living in major metropolitan areas with a high cost of living; and
- BIPOC, and particularly Black households.

In Montgomery County, nearly 60% of older adult renters are housing cost burdened compared to 26% of older adult homeowners. Studies show housing cost burdened older adults who rent are more likely to move to a nursing home compared to older homeowners who are not cost burdened. Even if an older housing cost burdened adult is healthy and able to function on their own, studies show they are still more likely to move to a nursing home when compared to non-cost burdened adults.

Increasing access to social and economic supports, such as affordable housing for seniors, can help older adults choose the best option for aging based on their health needs. Research suggests that increased access to affordable housing for older adults could reduce the rate of unnecessary nursing home admissions.

Chapter 8. Recommendations

The County Council requested this report from the Office of Legislative Oversight (OLO) to better understand how federal, state, and local laws impact the operation of nursing homes in Montgomery County and how the Council could better support County nursing homes and their residents.

OLO found that the County has little oversight and enforcement authority for nursing homes. Regulations, and the enforcement and oversight of them, is generally divided between the federal and state government, including the Center for Medicare and Medicaid Services (CMS) at the federal level and the Office of Health Care Quality (OHCQ) in the Maryland Department of Health at the state level.

However, the County can play an important role at two levels:

1. By evaluating, supporting and/or developing programs that can help older adults in the County stay out of nursing homes or that can provide nursing home residents access to services they may not get in their facilities.

2. By advocating at the state level for critical changes that will improve the quality of care in nursing homes in the County and improve the County's ability to access and communicate with nursing home residents.

With these possibilities in mind, the Office of Legislative Oversight has five recommendations for the Council's consideration.

Recommendation # 1. Request that the County Executive assess what support services are available to older adults in the County, particularly to older adults in nursing homes, to identify and evaluate gaps in services.

County staff informed OLO of gaps in support services available to older adults, especially older adults residing in nursing homes. Multiple County staff shared concerns that older adults in nursing homes do not have access to County programs and activities for older adults (i.e., transportation, mental health services, tech support, recreation, legal aide, religious services, etc.) due, in part, to a lack of awareness by nursing home residents of County programs and to service providers assuming nursing home residents are receiving services through their respective facilities. However, the range of services offered to residents varies by nursing home, and County staff are concerned there are many nursing homes residents who are not receiving services they could greatly benefit from.

Further, staff report hearing feedback that the services provided by the County are often tailored to White residents, both in the location and type of programming offered, and that Black, Indigenous, and other people of color (BIPOC) older adults report feeling a lack of access to these services.

OLO recommends the Council ask the Executive to conduct an assessment that identifies and examines gaps in services for older adults in the County. The assessment should focus on:

- Accessibility of services;
- Racial equity and cultural competency of services; and
- Gaps in the type of services provided and community needs.

The Executive should use information on gaps in services to set priorities and implement projects that can close the gaps.

Recommendation # 2. Ask the County Executive to identify programming and needed funding that will address gaps in services for BIPOC older adults and nursing home residents that will lead to more equitable outcomes. Ask the County Executive to report on this work to the Council on a regular basis.

The pandemic has magnified existing systemic issues that disproportionately impact BIPOC older adults. The legacy of government racism and discriminatory laws and practices have negatively impacted where and how communities of color, particularly Black communities, live, work, go to school, and access health care. These historic and current inequities are key drivers of health disparities, which accumulate over the course of a lifetime and result in inequities in health care and outcomes for BIPOC residents in nursing homes.

Decades of research show that Black nursing home residents receive lower-quality care and experience worse health outcomes than White residents. Black nursing home residents are more likely than their White counterparts to be physically restrained, to be hospitalized for conditions associated with not receiving proper care, and to report lower quality of life. The pandemic laid bare these racial disparities as nursing homes with the lowest percent of White residents were more than twice as likely to have COVID-19 cases or deaths as those with the highest percent White residents.

Moreover, BIPOC nursing home residents are more likely to reside in poorly performing facilities. Nursing facilities that predominantly serve Medicaid residents – who tend to be Black and/or Latinx – are more likely to receive lower ratings, have fewer staff, and experience challenges complying with federal and state regulations. These facilities are also less likely to provide the same level of services as facilities that have more private insurance payers. This service gap provides an opportunity for County programs to fill.

To address these structural inequities, it is important to take an approach that focuses on systems, institutions, and the needs of BIPOC stakeholders. OLO recommends the County conduct systematic and comprehensive discussions with stakeholders to address racial disparities in nursing home care and examine how County programs can address inequitable services for BIPOC nursing home residents. The County should consider examining the following areas:

- **Opportunities to allow older adults to age in place**, such as supporting Medicaid waivers for home-based care and services, and funding for home health services, adult medical daycare, and personal care daily services that are not covered by Medicaid;
- **Increased outreach and technical assistance** to match older adults, especially BIPOC older adults, to County services and funding;
- **Increased access to culturally competent services** such as offering programming in multiple languages and more programming in communities where BIPOC residents reside; and
- **Increased transportation services** as County staff expressed concerns that transportation is a challenge for older adults, especially for nursing home residents. Transportation services increase access to specialty doctors, recreational activities, and community, including religious and cultural services.

Recommendation # 3. Develop more affordable housing in the County for lower to middle income older adults on fixed incomes.

In Montgomery County, nearly 60% of older adult renters are "housing cost-burdened," meaning they spend more than 30% of their household income on housing. Cost burden is of particular concern to older adults who are often on fixed incomes and generally have higher healthcare costs. Studies show that older adult renters who are housing cost burdened are four times more likely to move to a nursing home compared to older homeowners who are not cost burdened. Even if an older adult experiencing housing cost burden is healthy and able to function on their own, studies show they are still more likely to move to a nursing home when compared to non-cost burdened adults.

Housing cost burdened households are a symptom of not having enough affordable housing. Research suggests that increased access to affordable housing for older adults could reduce the rate of unnecessary nursing home admissions. As such, OLO recommends the Council continue its efforts to increase support for development of affordable housing for lower to middle income seniors so that older adults can choose the best housing option for aging based on their health needs.

Recommendation # 4. Work with the County Executive to address staff shortages in the County's nursing home workforce by strengthening County services and advocating at the state level.

Stakeholders report that the national health care workforce shortage, which has been exacerbated by the COVID-19 pandemic, is the number one challenge facing nursing homes in Montgomery County. Factors contributing to nurse shortages include increased workloads (resulting in higher levels of stress, burnout, and staff turnover) and poor pay and benefits (leading many nurses and nursing assistants to leave the profession entirely). This is a critical concern because research shows that nursing home staffing levels are directly correlated with the health and quality of life outcomes of

residents. Research has shown that high staff turnover and consistent understaffing can lead to significant resident harm.

Stakeholders report that Maryland is one of the only states that requires nurses who work in long-term care to obtain Geriatric Nurse Assistant (GNA) certification in addition to certification as a Certified Nurse Assistant (CNA). OLO interviewed nursing home industry stakeholders who noted that this additional requirement discourages many CNAs from entering the nursing home workforce in Maryland because GNA certification is both costly in time and money. Oftentimes in Maryland, hospitals and other healthcare settings offer higher salaries for CNAs than nursing homes, and do not require GNA certification.

OLO recommends that the Council collaborate with the Executive on the following strategies aimed at bolstering the nursing home workforce in the County:

- Collaborate with local colleges to strengthen the nursing pipeline;
- Increase access to wrap around services such as childcare and transportation that will help nursing students enter and remain in programs;
- Work with the state to hire more nursing faculty to train new nurses;
- Proactively support state legislation that increases wages and benefits for the nursing workforce; and
- Advocate at the state level to remove barriers to joining the nursing workforce, such as reexamining the need for Maryland's more stringent certification requirements.

Recommendation # 5. Work with the County Executive, County departments and the County's State Delegation to increase transparency into nursing homes in the County.

Before 2021, a long-standing Memorandum of Understanding (MOU) between the Maryland Department of Health and Montgomery County allowed a team of eight to 10 County surveyors employed by the Montgomery County Department of Health and Human Services (DHHS) to conduct certifications, surveys, and complaint investigations in nursing homes on behalf of the state. The state terminated the MOU in 2021 resulting in the loss of County surveyors creating a significant gap in the County's communication with nursing homes and nursing home residents and ending opportunities to observe the conditions inside nursing homes in the County.

One of the County's remaining points of entry into nursing homes is the Montgomery County Long-term Care (LTC) Ombudsman program. The County LTC Ombudsman is a federally mandated program whose representatives act as mediators and liaisons between residents, their families, facility staff, and government agencies to ensure residents receive the care they are entitled to. However, the County LTC Ombudsman's operations were severely impacted by the COVID-19 pandemic and its capacity to communicate and visit with residents has decreased significantly.

OLO recommends the Council discuss with the County Executive, DHHS, and the County's State Delegation strategies for increasing transparency into nursing homes in the County. The Council could consider the following approaches:

- Discuss with DHHS, including the Ombudsman program, ways to enhance the County's capacity to access and communicate with nursing homes and their residents (including through expansion of Ombudsman program volunteers);
- Discuss with the County's State Delegation opportunities to reestablish the MOU with the Maryland Department of Health that would allow for County surveyors to access nursing homes in the County; and
- Advocate for an increase in the number of state survey staff.

Chapter 9. Agency Comments

The Office of Legislative Oversight (OLO) shared final drafts of this report with staff from Montgomery County Government. OLO appreciates the time taken by staff to review the draft report and to provide technical feedback. This final report incorporates technical corrections and feedback from agency staffs.

The written comments received from the Chief Administrative Officer are attached in their entirety beginning on the following page.

OFFICE OF THE COUNTY EXECUTIVE

Marc Elrich
County Executive

Richard S. Madaleno
Chief Administrative Officer

MEMORANDUM

July 19, 2023

TO: Chris Cihlar, Director
Office of Legislative Oversight

FROM: Richard S. Madaleno, Chief Administrative Officer

SUBJECT: Comments to Draft OLO Report 2023-7, *Nursing Homes in Montgomery County: Regulatory Framework and Issues Impacting the Quality of Care*

Thank you for the opportunity to comment on the Office of Legislative Oversight's (OLO) Draft Report Draft OLO Report 2023-7, *Nursing Homes in Montgomery County: Regulatory Framework and Issues Impacting the Quality of Care.*

Nursing homes are key partners and service sites to support our aging and disable residents, and the County Executive wants to ensure that we are maximizing these resources so that these residents can have equitable access to support services. We are proud of the work that the Department of Health and Human Services (DHHS) and other departments do on a daily basis to support these communities.

A key element of the County's work with people living in nursing homes is the Long-Term Care Ombudsman Program (LTCOP). There are three overarching priorities guiding the work of the LTCOP.

1. The program is a committed advocate for the care and health of Montgomery County's nursing home residents. Each individual residing in a nursing home facility deserves to live in an environment that acknowledges their individuality, while providing excellent customer service. Prior to COVID-19, the LTCOP visited each nursing home monthly, a cadence above and beyond the quarterly visitation requirement established by the Administration for Community Living (the program's funding source). Maintaining a regular presence in nursing homes is a priority and hence we are working toward filling program vacancies to resume the monthly visitations.

2. The LTCOP is also committed to educating residents and their families about ensuring that nursing home residents are served with dignity and respect. This is achieved via engagement with a nursing home's leadership, in partnership with the resident and their loved ones.

3. The LTCOP prioritizes training, by developing and leading trainings for nursing home staff and administration.

Unfortunately, the Memorandum of Understanding (MOU) between the Maryland Department of Health (MDH) and the Montgomery County Department of Health and Human Services (DHHS) that allowed DHHS inspection of nursing homes was ended by the state in 2021. Since the sunset of the MOU, DHHS' Public Health Services (PHS) Licensure and Regulatory (L&R) Services has made several attempts to reinstate the MOU. DHHS/PHS has had several meetings with MDH, written letters to the state legislative delegation, and worked with legislative liaisons to reinstate the MOU or establish a new agreement that will facilitate a regular presence from MDH-Office of HealthCare Quality (OHCQ) in Montgomery County nursing homes.

The Commission on Aging (COA), which serves as the advisory group to the Area Agency on Aging (AAA) as required by the Older Americans Act (OAA), has prioritized the impact of OHCQ's MOU withdrawal since its expiration in 2021. With the absorption of all state inspections within MDH OHCQ, there has been a significant decline in transparency coupled with significant decline in its presence at Montgomery County nursing homes. The COA has submitted letters to the members of the delegation expressing the dire need for nursing home inspections and enforcement efforts within the County's facilities. Coordination with OHCQ remains a critically important FY24 budgetary and policy priority.

The report contains the following recommendations.

Recommendation #1: Request that the County Executive assess what support services are available to older adults in the County, particularly to older adults in nursing homes, to identify and evaluate gaps in services.

CAO Response: We agree that this effort would generate the key information needed for planning the next steps. At this time, DHHS Aging and Disability Services does not have adequate and appropriate staff to conduct this assessment, however, this task will be completed once we have sufficient resources.

When a formal needs assessment is conducted, it will assist the County Executive to make budget and service enhancement recommendations to address equity and ensure that our County's older adults, particularly those in nursing homes, can have access to the services that will meet their basic needs and enhance their quality of life. Some of these recommendations may ultimately be directed towards the state, who oversees nursing home performance in the wake of the MOU termination.

The County's Long-Term Care Ombudsman Program (LTCOP) regularly connects residents to other Montgomery County services that may provide additional support on a case-by-case basis, however, we recognize that there may be gaps in services that could be addressed. Some of these services include Adult Protective Services (APS), Community First Choice (CFC) Waiver program, Senior Assisted Living Subsidy (SALs), and Guardianship.

Recommendation #2: Ask the County Executive to identify programming and needed funding that will address gaps in services for Black, Indigenous, and other people of color (BIPOC) older adults and nursing home residents and will lead to more equitable outcomes. Ask the County Executive to report on this work to the Council on a regular basis.

CAO Response: We agree with this recommendation.

As stated above, the LTCOP team is significantly understaffed. Since COVID-19, the volunteer-dependent program lost more than fifty percent of its volunteer workforce. In addition, the program is operating with only three certified merit ombudsmen. There are currently four vacant staff positions in the LTCOP.

The LTCOP serves as advocates for all nursing home residents who contact the program for assistance. Understanding that older adult BIPOC communities have varied cultural differences, the LTCOP makes every attempt to assign an advocate to a nursing home where there are similarities in cultural or ethnic backgrounds. For example, a volunteer ombudsman who is Korean was assigned to one of the nursing homes with a historically large Korean population. This assignment made a tremendous positive impact on the Korean residents' quality of life and care at the facility.

Bilingual Spanish-speaking staff often accompany monolingual staff or volunteer advocates on visits to nursing homes for residents whose only or primary language is Spanish. In addition, staff ombudsmen conduct trainings on Person-Centered Care for nursing home staff. Person-Centered Care enables nursing home staff to recognize the individual differences – including ethnic and cultural differences – of each resident. The goal of Person-Centered Care is to create an environment that follows the residents' routines rather than those imposed by facility staff. Truly individualized care often results with the implementation of Person-Centered Care.

It should be noted that previous LTCOP volunteers have been members of the Commission on Aging and affiliated with various minority-serving groups. In order to recruit volunteers that are connected with diverse communities, the LTCOP implements a variety of strategies, such as working with the DHHS African American Health Program (AAHP). We hope to leverage AAHP's connections throughout the community to recruit additional volunteers. Moreover, once fully staffed, the LTCOP will prioritize education and outreach to ensure that all County programs and services are aware of the available nursing home support services.

The same disparities that exist in the community are exhibited in the microcosm of nursing homes. We agree that it is necessary to identify programs that will lead to equitable outcomes within the BIPOC older adult community. Therefore, through the expertise of the County's Health Officer, along with the DHHS minority health initiatives/program, DHHS will develop a plan of action to address these disparities.

Recommendation #3: Develop more affordable housing in the County for lower to middle income older adults on fixed incomes.

CAO Response: We agree with this recommendation.

There needs to be an exploration of additional options for housing vulnerable older adults. Not all older adults require the intensive supports offered in nursing homes and additional low-cost housing options are a more reasonable living environment in those cases. One alternative may be assisted living facilities for older adults with low to middle incomes who do not qualify for Medicaid. DHHS staff is currently participating in a multi-sector private/public workgroup led by DHCA to identify housing alternatives, facility funding, and additional resources to meet the needs of older adults with low to middle incomes.

Recommendation #4: Work with the County Executive to address staff shortages in the County's nursing home workforce by strengthening County services and advocating at the state level.

CAO Response: We agree with this recommendation.

Consistent with the recommendation for a needs assessment and potential recommendations that such an assessment would identify, the County can work with state and federal partners to identify supplemental programming and advocacy opportunities that would offset some of the challenges in nursing home staffing and resources.

Locally, the County Executive has been proactive in this area. In March 2022, the County Executive appointed a Home and Community Based Services (HCBS) Workforce Taskforce to examine staff shortages. HCBS is inclusive of nursing home staff. The taskforce was charged with the following.

- Studying the County's current state of HCBS to identify service gaps and the workforce necessary to successfully deliver these services.
- Identifying economic and public health challenges associated with the delivery of in-home care.
- Developing an action plan to address identified gaps and formulate *actionable* strategies to benefit recipients of care, caregivers, care providers, agencies, County government, and the region.

- Identifying Montgomery County entities charged with the implementation of the action plan.

The taskforce recommendations were presented to the County Executive, the County Council HHS Committee Chair, and Executive Staff in April 2023. The taskforce provided twenty-six comprehensive and realistic local, state, and national recommendations that would bring about meaningful changes to recruit, retain, and address HCBS staff shortages. Next steps entail presenting the findings/recommendations to the County Council and the Maryland Secretary of Health.

Recommendation #5: Work with the County Executive, County departments, and the County's state delegation to increase transparency into nursing homes in the County.

CAO Response: We agree with this recommendation.

With the loss of local oversight and transparency associated with the termination of the MOU by the state, additional advocacy is required to ensure that the state is meeting this requirement for accountability.

The OLO report recommends that the County's state delegation work to increase transparency in nursing homes, especially with the recent increase in changes of ownership of local facilities. MDH-OHCQ recently hosted a webinar on Nursing Home Change of Ownership (CHOW). An overview of the Maryland's CHOW process was provided. The information will be posted on its website. In addition, OHCQ also recently noted that the Centers for Medicare & Medicaid Services released a memo that adds the posting of Nursing Home Ownership/Operatorship Affiliation Data on the Nursing Home Care Compare website.

Unfortunately, the move to a more technological, online-based platform for information sharing and gathering without first confirming if our target audience has access to the information or can access the information can significantly dilute the goal of transparency and resource sharing.

The removal of the local PHS L&R team has resulted in numerous complaints from residents and their families regarding deteriorating conditions at local nursing homes. This uptick in complaints has resulted in increased calls to the LTCOP team. Although the LTCOP has no enforcement capabilities, the nature of its work allows the team significant presence in the County's nursing homes. The team can substantiate the conditions impacting the quality of life and the quality of care experienced by nursing home residents. We agree that there needs to be more transparency in all long-term care facilities within the County. However, additional steps are required to best serve the County's older residents. Such changes include the revision of existing codes, empowering nursing home staff, creating equitable environments, and enhanced collaborations with our public and private partners.

We look forward to discussing these items at the Council work session.

RM/jb

cc: Fariba Kassiri, Deputy Chief Administrative Officer, Office of the County Executive
Ken Hartman, Director of Strategic Partnerships, Office of the County Executive
Sonia Mora, Assistant Chief Administrative Officer, Office of the County Executive
James Bridgers, Director, Department of Health and Human Services
Patrice McGhee, Acting Chief, Aging & Disability Services, Department of Health and Human Services
Chris Rodgers, Acting Chief, Public Health Services, Department of Health and Human Services
Leslie Frey, Intergovernmental Relations Legislative Analyst, Department of Health and Human Services
Kenneth Welch, Acting Senior Administrator, Department of Health and Human Services

Attachment 1: Nursing Home Resident's Rights and Services in Maryland Code of Regulations

Under the Code of Maryland Regulation 10.07.09.08, Maryland nursing home residents are afforded the following rights and services:

A. A nursing facility shall provide care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, and in full recognition of the resident's individuality.

B. A nursing facility may not interfere with a resident's exercise of rights guaranteed under the Constitution or laws of the United States and Maryland.

C. A resident has the right to:

(1) Reside and receive services in a nursing facility with reasonable accommodations of individual needs and preferences, except when accommodations would endanger the health or safety of the resident or other residents;

(2) Receive treatment, care, and services that are in an environment that promotes maintenance or enhancement of each resident's quality of life;

(3) A dignified existence, self-determination, and communication with and access to individuals and services inside and outside the nursing facility;

(4) Be free of interference, coercion, discrimination, or reprisal from the nursing facility when exercising the resident's rights;

(5) Be free from:

(a) Physical abuse;

(b) Verbal abuse;

(c) Sexual abuse;

(d) Physical or chemical restraints imposed for purposes of discipline or convenience;

(e) Mental abuse; and

(f) Involuntary seclusion;

(6) Choose an attending physician, if the physician agrees to abide by nursing facility policies and procedures, and the regulations in this chapter;

(7) Choose a pharmacy to obtain medications as set forth in COMAR 10.07.02.15B(3) and D(3);

(8) Be fully informed in advance about care and treatment, and of proposed changes in that care or treatment;

(9) Participate in planning care and treatment, or changes in care or treatment;

(10) Seek advice from the resident care advisory committee concerning the options for medical care and treatment for an individual with a life-threatening condition in accordance with Health-General Article, §19-370 et seq., Annotated Code of Maryland;

(11) Consent to or refuse treatment, including the right to accept or reject artificially administered sustenance in accordance with State law;

(12) Self-administer drugs if the interdisciplinary team determines that the practice is safe;

(13) Access the resident's records within 24 hours, excluding weekends and holidays, upon an oral or written request;

(14) Purchase copies of all or part of the resident's records upon request by giving 2 working days advance notice to the nursing facility;

(15) Approve or refuse the release of personal and clinical records to an individual outside the nursing facility unless:

(a) Otherwise provided by Health-General Article, §4-301 et seq., Annotated Code of Maryland; or

(b) The release is required by law;

(16) Personal privacy, including:

(a) Confidentiality of personal records; and

(b) Privacy in:

(i) Medical treatment, and

(ii) Personal care;

(17) Privacy in the resident's room, including the right to have nursing facility staff knock before entering the resident's room;

(18) Privacy in written communication, including the right to:

(a) Send and receive mail promptly without it being opened by anyone other than the resident, except when the resident requests assistance; and

(b) Have access to stationery, postage, and writing implements at the resident's own expense;

(19) Reasonable access to the private use of a telephone;

(20) Meet or visit privately with any individual the resident chooses, subject to reasonable restrictions by the nursing facility on visiting hours and places;

(21) Visit or meet privately with the following, to whom the nursing facility shall provide reasonable access:

(a) A representative of the Secretary of the U.S. Department of Health and Human Services;

(b) A representative of the Department;

(c) The resident's personal physician;

(d) A representative of the State Long-Term Care Ombudsman Program;

(e) The agency responsible for advocacy and protection of developmentally disabled and mentally ill individuals in Maryland; or

(f) Any other legal representative;

(22) Visit privately with the resident's spouse or domestic partner;

(23) Consent or deny consent to all visits, and may deny or withdraw consent at any time;

(24) Examine the results of the most recent federal and State surveys, including the annual survey and any subsequent complaint investigations, not otherwise prohibited by law, of the nursing facility and any plans of correction prompted by these surveys;

(25) Receive notice before the resident's roommate is changed and, to the extent possible, have input into the choice of roommate;

(26) Voice grievances, including those about treatment or care that is or fails to be furnished, and recommend changes in policies and services, to the staff or administrator of the nursing facility, the Licensing and Certification Administration, the Office on Aging, or any other person, without fear of reprisal, restraint, interference, coercion, or discrimination;

(27) Prompt efforts by the nursing facility to resolve grievances the resident may have, including those with respect to the behavior of other residents;

(28) Contact and receive information from agencies acting as client advocates;

(29) Refuse to perform services for the nursing facility;

(30) Perform services for the nursing facility if the resident chooses, only if:

(a) The nursing facility has documented the need or desire for work in the plan of care;

(b) The plan specifies the nature of the services to be performed and whether the services are voluntary or paid;

(c) Compensation for paid services is at or above prevailing rates; and

(d) The resident agrees in writing to the work arrangement described in the plan of care, and the contract is part of the resident's record;

(31) Share a room with the resident's spouse if both spouses consent and it is not medically contraindicated; and

(32) Participate in social, religious, and community activities if the activities do not interfere with the rights of other residents in the nursing facility.

D. A resident has the right to participate or refuse to participate in experimental research. When the resident is incapable of making this decision, the resident's appropriate representative may consent for participation in therapeutic experimental research only.

E. The resident or, when applicable, the resident's health care representative, has the right to be fully informed, in a language that the resident or representative can reasonably be expected to understand, of complete and current information about the resident's diagnosis, treatment, and prognosis, unless it would be medically inadvisable as documented by the resident's attending health care provider. If this determination has been made, the health care provider shall, upon written request:

(1) Make a summary of the undisclosed portion of the medical record available to the resident or health care representative;

(2) Insert a copy of the summary in the medical record of the resident;

(3) Permit examination and copying of the medical record by another health care provider; and

(4) Inform the resident or health care representative of the resident's or health care representative's right to select another health care provider.

F. Resident and Family Groups.

(1) A resident has the right to organize and participate in resident groups in the nursing facility.

(2) A resident's family has the right to meet in the nursing facility with the families of other residents.

(3) Staff or other visitors may attend meetings only at the group's invitation.

Attachment 2: Demographics of Older Adults in Montgomery County

Demographics of Older Adults (aged 65 and older) in Montgomery County

Characteristics	Percent of Older Adults
Sex and Age	
Male	44%
Female	56%
Median Age	73.4
Race/Ethnicity	
American Indian and Alaska Native	0.2%
Asian	16.2%
Black or African American	13.3%
Hispanic or Latino Origin (of any race)	9.6%
White	59.4%
Some other Race	4.9%
Two or more Races	6%
Household Characteristics	
Married Couple Family	47.4%
Householder Living Alone	41.3%
Living with Grandchild(ren)	6.9%
Responsible for Grandchild(ren)	0.5%
Owner-Occupied Housing Units	79.7%
Renter-Occupied Housing Units	20.3%
Income in the Past 12 Months	**(in 2021 Inflation-Adjusted Dollars)**
With Earnings	46.1%
With Social Security income	77.2%
With Supplemental Security Income	4.2%
With Cash Public Assistance Income	1.9%
With Retirement Income	65.3%
With SNAP Benefits	5.6%
Poverty Status in the Past 12 Months	
Below 100% of the Poverty Level	8.1%
100-149% of the Poverty Level	3.4%
At or above 150% of the Poverty Level	88.5%

Source: 2021 American Community Survey 1-Year Estimates