A Home for the Rest of Your Life

Continuing-care communities promise independence now and all the help you need later on.

By: JANE BENNETT CLARK

Four days. That’s how long Lucy and Dick Thomson had to make the decision of a lifetime: Stay in Saginaw, Mich., where they had met before World War II, or pull up stakes and move to a cottage that they had never seen in a new development that was swimming in mud. The couple had placed a small deposit on a cottage at the unfinished site in Lake Forest, Ill., at the urging of their son, who lives nearby. But they were taken aback when the call came that the cottage was available. The message: Grab it now or lose your place in line. That was six years ago.

Today, the Thomsons smile at the memory as they show off their two-bedroom cottage, a sunny space decorated in pale green, yellow and cream. The couple, both 84, enjoy good health and a full calendar at Lake Forest Place, a continuing-care retirement community run by the Presbyterian Homes, in Evanston, Ill. Should their health fail, they are assured of getting help, either in their home or elsewhere on campus. Says Lucy, “it was the best decision we’ve made in our whole life.”

Lake Forest Place is one of 2,100 continuing-care communities across the country that offer independent living, in either cottages or apartments, along with various levels of care. Unlike assisted-living facilities, which can ask you to leave when your money runs out or you need skilled nursing, these communities promise to keep you for life, usually in exchange for an upfront six-figure deposit and monthly fees. Most offer amenities such as fitness clubs, restaurant-style meals and a busy social schedule. Says Linda Fodrini-Johnson, a geriatric-care manager with an office in San Francisco, “It’s a nice choice for the healthy senior who wants to be socially engaged.”

Continuing-care communities also present a conundrum: To qualify, you must be reasonably healthy—healthy enough that you could still stay in your own home. In fact, most retirees remain in their homes or go directly to assisted living at about age 80 or older. Those who do enter a life-care community typically wait until they are at least 75.

But moving to the right place at the right time can prolong your vitality, says Karen Love, founder of the Consumer Consortium on Assisted Living. The communities are “wonderful environments because they’re supportive,” she says. “Typically, the food is excellent. There’s transportation. If I want a buddy to go shopping with, there are tons of people to pick from.” You could actually live longer and healthier in such settings, says Larry Minnix, president of the American Association of Homes and Services for the Aging. “They give the services that people need when they need them, in a place they can call home,” Minnix says.

The Thomsons had no immediate plans to leave Saginaw six years ago, but they did have compelling reasons to move someday. All four of their parents had ended their
days in grim nursing homes, and the couple’s four children had already moved away. “We were wondering what our parents were going to do,” says Richard Jr., known as Tom. When Lake Forest Place sprang up near his home outside of Chicago, the family saw an opening. Says Dick, a pilot who parachuted out of his aircraft after it was hit over Hungary during World War II, “It was time to hit the silk.”

Go in With Your Eyes Open

It’s easy to see why the Thomsons are pleased with their decision. The sea of mud is long gone, and their cottage, which backs to a beautifully landscaped area, boasts a full kitchen, a laundry room and a garage. In the Town Center, the community’s main building across the road, the paneling, arched windows and overstuffed chairs easily compete with the ambiance of any country club. Residents can work out in the fitness club or take a dip in one of the community’s several pools.

But Dick steers clear of the parts of the complex that offer nursing care or help with eating and dressing. “When it comes to assisted living, I’m in denial,” he admits. And he’s not alone, says Laurie Duncan, a CPA who owns Choices for Aging, a geriatric-care management company in Arlington, Va. “People like to look at the apartments, the dining facilities—but when you suggest a visit to the health facilities, they say, ‘No thanks.'”

As understandable as the ostrich approach might be, anyone looking to secure a comfortable future should “make sure they tour every bit of a community, including the assisted-living and nursing-home areas,” says Nicole Muller of Brecht Associates, a firm that specializes in senior housing. Odors, poor housekeeping or residents who look parked are obvious red flags. “The atmosphere should feel comfortable to the person looking at it, not scary.”

Lake Forest Place can rightly boast of its caregiving: It’s accredited by the Commission on Accreditation of Rehabilitation Facilities. (To find out if a facility has earned the commission’s okay, go to www.carf.org.) State inspection reports, required for assisted-living and nursing-home units, provide another glimpse into quality control—if you can decipher them. Geriatric-care managers offer insight into such reports, as well as the skinny on local retirement communities. To find one in your area, call the National Association of Professional Geriatric Care Managers, at 520-881-8008, or go to www.caremanager.org.

Whatever the measuring stick, facilities that come up short, says Duncan, usually share the same problem: poor staffing. “You can have a beautiful lobby, but if you don’t have the staff, you’re not going to give good care,” she says. “If you’re paying minimum wage and don’t have good training—that’s where the rubber meets the road.”
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The bottom line is that good care giving requires plenty of willing arms, Duncan says. “In the nursing units, if you have one aide for every nine residents, each resident is getting much less than one hour of one-on-one care during a shift. If one aide is out, then are residents going to get showered or moved? On the assisted-living end, people who need help getting in and out of bed or a chair won’t get help if there’s only one aide for 15 residents.”

Assuming the care and staff are top-notch, you’ll need to explore how much help can be brought into your apartment before the community moves you from one level to another, especially when dementia is involved. Grouping cognitively impaired residents isn’t necessarily bad, says Gail Kohn, of Linking Partners, a long-term-care consulting firm. But be sure to ask whether and how it is done.

Some states dictate the circumstances in which you will be moved from an assisted-living to a nursing unit; in others, the managers of the community—preferably with the input of family members—make the call. Either way, ask how many nursing beds have been set aside for residents, says Chris Cooper, a registered financial adviser in Toledo who specializes in geriatrics. In a large community, “if there are only 12 beds, they could be full when you need them.”

The path between independent living and the nursing unit doesn’t have to be one-way. At Lake Forest Place, for instance, stroke victims and surgery patients can practice getting in and out of a full-scale car or climb stairs in the rehab center, giving them a leg up on recovery. The Erickson Retirement Communities, based in Baltimore, go a step further: They have doctors and other health-care providers on their campuses. “That’s a big innovation,” Minnix says.

A New Beginning

Just how do two people trade the house where they have lived for 45 years—and the town where they met, married and raised four kids—for a community of total strangers? Piece of cake, says Lucy Thomson. “We’ve met tons of people. We invite them over for a drink, then go to the town center for dinner. When you go, you have to mingle and it’s boy-girl-boy-girl. Everyone has been reading something different. You exchange ideas.”

Her son Tom, who heads the microbiology laboratory at Evanston Northwestern Health Care, happily concurs. “We thought it would be hard for our parents to pull up roots from the town where our family had been for generations, but it just worked,” he says. “In Saginaw, they knew everyone and had done everything. This has been a social rebirth.”

The Thomsons connected in their new setting in part because the residents of life-care communities tend to be likeminded, says Fodrini-Johnson. “These are bright
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people who are used to doing the research and finding the answers to complex problems.” Dick, who spent his career manufacturing automotive parts, agrees with that assessment. “The whole campus is composed of top professionals.”

Still, each community has its own flavor. For instance, the Kendal Communities—most of whose small campuses are located near liberal-arts colleges—attract residents who want to take classes or participate in campus functions. The Erickson communities draw members who like a wide range of activities. Religion, politics and socioeconomic status each play a role in the matchmaking process, says Kohn.

But little things like dining-room seating arrangements can be an important indication of how thoughtfully a community brings you into the mix. At the Erickson communities, for instance, residents are led to tables by a hostess rather than left to hunt for a seat. “You never sit alone,” says Trudy Couch, who lives in Riderwood Village, in Silver Spring, Md. Couch spent several nights in the guest suites at Riderwood to get a feel for the place before moving in. “I noticed how friendly the staff members were.”

Although the Thomsons first visited Lake Forest Place as a mud hole, any uncertainty about their move has vanished. Lucy attends yoga class or walks the trail beyond her house in the morning. Dick has taken a spot on the finance committee. They meet friends for dinner in the dining room three or four times a week. Says Lucy, “We’ve never been happier.”

Original Article can be found at Kiplinger’s, May 2005.

Instructor’s notes:

Be certain that you read BOTH articles in this PDF document and write your essay using information from both articles. As always follow the instructions for essays found in the “student essay” link in “Course Information”.

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Two decades after the passage of a federal law to clean up the nation’s nursing homes, bad care persists and good homes are still hard to find.

In 1987, Congress passed a landmark law meant to improve nursing home care for the elderly. But our investigation reveals that poor care is still all too common, especially at nursing homes run by for-profit chains, now the dominant force in the industry.

CONSUMER REPORTS’ analysis found that not-for-profit homes generally provide better care than for-profit homes, and that independently run nursing homes appear to provide better care than those that are owned by chains. In a separate study, we found that many states are lax in penalizing bad homes.

For this report, we analyzed the three most recent state inspection reports for some 16,000 nursing homes across the U.S. We also examined staffing levels and so-called quality indicators, such as how many residents develop pressure sores when they have no risk factors for them.

The Consumer Reports Nursing Home Quality Monitor, formerly the Nursing Home Watch List, is available free at www.ConsumerReports.org/nursinghomes.

It lists facilities in each state that rank in the best or worst 10 percent on at least two of our three dimensions of quality. By examining the kinds of homes that tend to cluster at either end of the continuum, we can make some judgments about how likely a facility is to provide proper care.

This year’s list, financed by a grant from The Commonwealth Fund, a philanthropic organization, is the fifth we’ve published since 2000. We’ve seen little evidence that the quality of care has improved since then. Indeed, 186 of the homes cited for poor care on this list have also appeared on earlier lists of poor-quality homes.

Consider the White Blossom Care Center, part of a for-profit chain in San Jose, Calif. From the outside, it looks like many of the nursing homes that dot the California landscape: wings of residents’ rooms and a parking lot full of cars. Inside we saw nothing that would arouse unease. Residents nodded off in wheelchairs, and aides chatted at nurses’ stations as an occasional visitor walked through the halls.

White Blossom, though, is no ordinary nursing home. It’s one of 12 that have been on each of our lists of poorly performing homes since 2000. Its state inspection, conducted last August and current when our reporter visited in December, raised troubling questions about the care it delivers.
Nursing Homes: Business as Usual

Page after page of the unusually long document detailed failures to follow doctors’ orders, perform a pain assessment, monitor pressure sores, screen for tuberculosis, or properly sanitize dishes and utensils. The 43-page report told of a stroke victim with swallowing problems who was left unsupervised with mushy material in her mouth. And it mentioned a medication error that could have been fatal. The survey also reported on the facility’s plans to correct the deficiencies that were cited.

The survey, which by federal law must be “readily accessible” in every nursing home, was not visible in the lobby when our reporter arrived. Only after she insisted on seeing it did the home’s administrator produce it. A staff member at the front desk said the report wasn’t initially available because it was being used by someone else at the time. Steven Earle, White Blossom’s administrator, wouldn’t comment on specific deficiencies but said that they had been corrected.

In the three most recent state surveys we analyzed, 657 homes across the country were cited for failing to make their inspection results readily accessible.

Skimping on Care?

While our investigation suggests that you or a family member might receive better care at a not-for-profit, independently owned facility, they make up a small portion of the industry. Since the establishment of Medicaid, the state and federal program for the poor and the elderly, in the 1960s, for-profit homes have come to dominate the field.

CR Quick Take

Our investigation found that the state agencies responsible for overseeing nursing home care have often failed to correct problems. But consumers can increase their odds of choosing a good nursing home if they narrow their search to certain types. Our findings:

- Not-for-profit homes are more likely to provide good care than for-profits, based on our analysis of inspection surveys, staffing, and quality indicators.
- The same analysis shows that independently run homes are more likely to provide good care than chains.
- Through its influence in politics, the industry has whittled down the protections of the 1987 federal law.
"In some chains we see facilities that will consistently do poorly," says Paul Dreyer, director of licensing and certification in the Massachusetts Department of Public Health. "Sometimes it hasn’t been the chain’s priority to make facilities the best they can be. The focus is maximizing some kind of return to investors."

Bruce Yarwood, president and CEO of the American Health Care Association (AHCA), which represents primarily for-profit homes, says that poor homes are a "chronic, tough issue." He notes that many nursing home executives have trouble escaping Wall Street’s quarterly earnings pressure. But, he says, “For every bad story there are probably 50 good ones.”

Nursing home researchers say that the most serious problems sometimes show up in small, for-profit chains within a state. In New York, for example, Healthcare Associates, wholly owned by Anthony Salerno, jointly administers a network of 12 separately incorporated facilities. Salerno is the largest shareholder in all the facilities. Three of the homes have been on our quality-monitor list.

Earlier this year Eliot Spitzer, New York’s attorney general, sued one of the three homes, the Jennifer Matthew Nursing and Rehabilitation Center in Rochester, alleging abuse and neglect. Investigators used a hidden camera to show that call bells were placed out of residents’ reach and that patients would go unturned and unwashed for hours. That facility was a four-time repeater on our lists. The legal case is ongoing; a lawyer for the center did not respond to requests for comment. 

One reason the independently owned, not-for-profit facilities might do a better job is that they tend to have more staff, which experts agree is crucial to good care. We found that on average, not-for-profits provided almost an hour of additional nursing care each day per resident, compared with for-profit facilities. They also provided nearly twice as much care from registered nurses.

In 2002, a study conducted for the federal Centers for Medicare & Medicaid Services (CMS) noted that without a daily average of 2.8 hours of care from nurse aides and 1.3 hours from licensed nurses, residents were more likely to experience poor outcomes—pressure sores and urinary incontinence, for example. “Most nursing homes are staffed significantly below that,” says John Schnelle, director of the Borun Center, a joint venture of UCLA and the Jewish Home for Aging that does research on long-term care.

The CMS, however, has not recommended or adopted minimum staffing standards, a point of contention for nursing home advocates, who are pushing for them. Marvin Feuerberg, a technical director at the CMS, says officials even watered down the 2002 study’s executive summary when it was given to Congress.
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Instead, current rules say that staffing must be sufficient to meet the needs of nursing home residents, a standard so vague that it makes penalizing nursing homes that skimp on care almost impossible. Rules do require homes to have 8 hours of registered nursing and 24 hours of licensed nursing coverage per day. But the standard applies to all homes, no matter how many residents they have. So a nursing home with 200 residents can use the same-size staff as one with 20.

Inadequate staffing puts residents at risk. Glen Barnhill, 46, of Nashville, lived in Tennessee nursing homes for several years after he suffered a gunshot wound to the head. Barnhill, a quadriplegic who needs a ventilator to breathe, says he would sometimes go into respiratory distress while waiting for a call light to be answered. “I’d be in bed gasping and fighting for air, not knowing when the nurse would come,” he says.

The AHCA says that minimum staffing rules cannot be an unfunded mandate on the part of the government. “If you’re required to have x amount and certain types of staff, you need reimbursement,” says Sandra Fitzler, the group’s senior director of clinical operations. More money from Medicaid, which pays for more than half of all nursing home stays, would improve staffing, the industry says.

But money is not always the problem. We examined Medicaid reimbursement for nursing homes in 2002, the last year for which we had complete data. We found no evidence that the average state Medicaid payment to nursing homes had a significant impact on the percentage of homes identified as poor performers.

Playing Politics

Nursing homes are not major donors to national political campaigns, but they wield considerable clout in state capitals, where their $500, $1,000, and $3,000 contributions count with gubernatorial, state legislative, and judicial candidates.

In Arkansas, for example, the industry was a top contributor to state candidates in 2004, according to Followthemoney.org, a nonpartisan database of campaign contributions. The Arkansas Health Care Association, which represents for-profit nursing homes, gave almost $100,000 that year to candidates in the state.

The trade association also maintains an office near the Arkansas Capitol in Little Rock, where legislators can stop in and enjoy a free lunch three times a week during legislative sessions.

“They contribute a large amount of money to people’s campaigns” and the politicians become beholden, says state Sen. Mary Anne Salmon, a Democrat. She
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adds, “Nursing homes have stopped some very good legislation that would have made things better for the elderly.”

Messages from legislators, subtle and not so subtle, filter down to regulators, who have learned that nursing homes will challenge them if they press too hard. Grachia Freeman, a former nursing home inspector in Arkansas, says that supervisors “would not let me write deficiencies I wanted to write” for a facility she was inspecting. Now a nurse at a VA hospital in North Little Rock, she adds, “They were angry with me for investigating and told me not to complete the survey.” We made several efforts to interview regulators in the long-term-care unit of the Arkansas Department of Health and Human Services but were repeatedly rebuffed.

This pressure “gives facilities the confidence to push back in so many ways, like appealing citations and sanctions because they know that state legislators tend to be very protective of homes in their districts,” says Iris Freeman, principal consultant with Advocacy Strategy, a Minneapolis firm that works with community groups on behalf of the elderly and disabled.

Shop smart

How You Can Find Good Nursing Home Care

Choosing a humane, well-run nursing home can be one of the most important decisions you’ll make in life. Unfortunately, it can also be one of the most rushed. Even when good information is available, you may have little time to digest it, especially if a hospital discharge planner says your relative must be out in 24 hours. He or she will often suggest a particular nursing home in the area, but you may not know whether the home is your best choice or a very bad one.

If you find yourself in this situation, first know that you can use your appeal rights under Medicare to extend the hospital stay for two days. That will buy you additional time. Then follow these steps:

Get the names of local facilities. The Eldercare Locator (800-677-1116) will refer you to your local agency on aging. It, in turn, can supply you with a list of nursing homes and contact information for the local ombudsman, a government official whose job is to investigate nursing home complaints and advocate for residents and their families.

Consult our Quality Monitor. (www.ConsumerReports.org/nursinghomes). It will help you cross potentially bad homes off your list. Avoid facilities that have appeared on our list repeatedly and those that performed poorly on two of our three dimensions of quality. If a nursing home near you is on our “good” list, put it on your list of possibilities. Also check state penalty information on our site. If a nursing home has received a state fine, even a small one, consider that a warning.
Nursing Homes: Business as Usual

Check the ownership. A resident’s chances of receiving good care are better at an independent not-for-profit facility than at a for-profit chain. You should ask whether the facility is about to (or has) changed owners. One that’s on the auction block might have problems, just as one with a new owner might be getting better. Be aware that if the facility is part of a large corporation that has split itself into smaller, limited-liability companies, you may have little recourse against the home if things go badly for your family member.

Check with the local ombudsman. He or she should be able to tell you about homes in your area. We say “should” because many ombudsmen have encountered pressure from the industry and are now very careful about what they say. Comments such as “You may want to look further” or an unenthusiastic “They’re OK” could be warning signals.

Don’t depend on the federal Web site. The Centers for Medicare & Medicaid Services maintains a Nursing Home Compare site at www.medicare.gov. But our comparison of the information on that site and the state inspection reports on which it is based show that you’ll probably get an incomplete and possibly misleading picture of any home that you have under consideration.

Visit the homes. Once you’ve narrowed your search, make unannounced visits. Connie Smith of Little Rock, Ark., visited five homes, several repeatedly, before selecting the Greenhurst Nursing Center in Charleston, Ark., for her son Jordan, 23, who as a child became a quadriplegic due to a BB gun accident. She’s pleased with the personal attention he has received. When Jordan turned 21, the nursing home administrator put a drop of beer on his lips to mark his coming of age.

Read each home’s Form 2567. That is the facility’s state inspection survey, which should be “readily accessible.” If it’s not and you have difficulty obtaining it, consider that a warning that the facility may be hiding damaging information. A lengthy survey with lots of violations indicates problems. The administrator might tell you they’ve been fixed, which may or may not be true. But even a deficiency-free survey is no guarantee of good care. It may merely mean that the inspectors were not looking very hard.

Visit the homes again. Drop in between 9:30 and 10 n.m., for example, to see how many people are still in bed. Homes with too few staff members don’t get people out of bed until late in the day, if at all. Also visit at dinnertime. If 75 percent of the residents are eating in their rooms, that’s not a good sign. Most people prefer to be out of bed and to eat in the dining room. Ask the nurse aides how many residents they each care for. The smaller the number, the better.

Ask about top-level turnover. If the administrator and the director of nursing have worked at a facility for several years, that’s a positive sign. Frequent changes in those positions indicate instability, which could translate into poor care.
Talk to the administrator. Try to get a sense of his or her philosophy of care and how well it’s communicated to staff members. Good care begins with the facility’s leadership.

Easing Off of Enforcement

Although the number of deficiency citations written by state inspectors has increased 7.6 percent since 2003, according to the CMS, inspectors appear to be watering them down. Each one carries a letter code, from A through L, indicating the scope and severity of the violation. Citations labeled 0 through L denote actual harm or the potential for death. Codes I through L indicate that the harm was widespread, affecting many people.

State inspectors are now writing fewer deficiencies with codes that denote actual harm, such as avoidable pressure sores and medication errors. “We are going back to a less stringent and simpler enforcement,” says a federal analyst familiar with nursing home inspection data at the CMS. “Everything is becoming a D level. Nursing facilities are going to challenge anything above a D level if it carries a mandatory penalty, can be used in a tort case, or will be publicly disclosed.”

In 2000, 40 percent of all deficiencies carried a D designation. By 2005, the number had risen to 54 percent. The reason, says the analyst, is pressure from nursing homes on understaffed state agencies that find it hard to muster the resources to defend their citations in court.

The most common remedy for violations is a “plan of correction.” The nursing home acknowledges there is a problem and promises to fix it within a specified period. Often the problem is corrected but soon resurfaces, a phenomenon regulators call yo-yo compliance.

Token Fines or None at All

The 1987 nursing home reform law provided for monetary penalties that could be imposed by states and the federal government. But that hasn’t meant that fines are collected. In fact, last year the federal Office of the Inspector General found that the CMS did not take all the required steps to collect 94 percent of past-due penalties.

Some states are doing no better. Even when inspectors find that homes are providing poor care, regulators may be slow to impose fines, if they levy them at all.
In 2003 and 2005, CONSUMER REPORTS examined whether states were levying fines against our sample of poorly performing homes. We found that the ones that could impose fines were not always using that authority. Our earlier study found that in states with the power to impose fines, only 55 percent of the facilities in our sample that could have received one actually did. In our most recent analysis, we found that states fined just 50 percent of such homes.

Eight of the 12 five-time repeaters on this year's list of poorly performing homes had not received state fines between 1999 and 2004. The others received minimal penalties. California regulators, for instance, fined White Blossom a total of $10,800 during the six years it was on our lists. The largest fine it received in any one year was $3,600.

When fines are assessed, they tend to be low, sometimes absurdly so. Consider the slap on the wrist given the Willow Tree Nursing Center in Oakland, Calif. In 2001, according to state records, a 38-year-old paraplegic with poor cognitive ability left the home on a pass. When he did not return until 2 a.m., the home’s administrator ordered a nurse not to let him back in. Regulators cited the facility for failing to keep a resident free from mental abuse and assessed a fine of $700. The state, however, collected only $455 and closed the case. Seventeen months later, the state again cited Willow Tree, for failing to report an allegation of abuse within 24 hours. This time, a nurse who allegedly put a pillow over a resident’s face, said, “I’m going to smother you,” and then walked out of the room laughing after the patient pushed it off. The state collected $600.

States can reduce an already meager fine by 35 percent if the nursing home agrees not to appeal. The median fine in 1999 for the homes we looked at was $4,800; in 2004 it had dropped to $3,000. Less than 2 percent of the homes received a fine greater than $100,000.

“The system hasn’t been hard enough on those who view penalties as the cost of doing business,” says David Hoffman, a former federal prosecutor in Philadelphia who has sued many nursing homes and now consults with the industry about improving the quality of its care.
Shutting Down a Home

The CMS can disqualify a home from the Medicare and Medicaid programs, cutting off federal funds. But that remedy, the most drastic in the agency’s arsenal, is used less frequently than in the past. In 1998, the number of terminations peaked at 51; in 2005 there were only 8.

States can also try to shut down what they judge to be poorly performing facilities. In 2005, Indiana regulators investigated a complaint that a student nurse aide at the Hanover Nursing Center in Hanover had beaten a resident in the face, an immediate-jeopardy violation. That inspection resulted in a 62-page report detailing numerous violations.

Regulators placed a 45-day ban on admitting new residents to the home but lifted it after further inspection. In February, Hanover’s license expired, and state officials refused to grant a new one. The facility is appealing the loss of its license and a federal fine of $117,500 for the immediate-jeopardy violation. Meanwhile, it continues to operate.

Full text can be found online at: Consumer Reports