REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

VOLUNTARY CLOSURE OF LONG-TERM CARE FACILITIES STUDY

(SB 845/HB 1920)

TO THE CHAIRMEN OF THE SENATE COMMITTEE ON EDUCATION AND HEALTH AND THE HOUSE COMMITTEE ON HEALTH, WELFARE AND INSTITUTIONS

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Preface

House Bill 1920 and Senate Bill 845, which were introduced during the 2001 General Assembly Session, provided statutory requirements and resident protections that would apply to any long-term care facility which chose to voluntarily close or "not to renew its license or Medicare or Medicaid provider agreement...." HB 1920 was left in the House Committee on Health, Welfare and Institutions; SB 845 was left in the Senate Committee on Education and Health. The House Committee on Health, Welfare and Institutions agreed to refer HB 1920 to the Joint Commission on Health Care (JCHC) for further study. The Senate Committee on Education and Health approved a motion to refer the issues presented in SB 845 for consideration by JCHC's Long-Term Care Subcommittee.

Based on our research and analysis during this review, we concluded the following:

- For nursing facilities, federal regulations require nursing facilities certified to receive Medicare or Medicaid to give residents 30 days notice prior to transfer or discharge. The *Code of Virginia* Title 32 requires licensed nursing facilities to give residents "reasonable advance written notice" prior to any transfer or discharge from the facility. Virginia Department of Health (VDH) licensing regulations require nursing facilities to provide written notification to VDH 30 working days prior to any licensing change including closure.
- In Virginia, very few nursing facilities have closed in recent years. No nursing facility has been involuntarily closed in the last eight years. There have been ten voluntary relocations and closures in the last four years.
- For assisted living facilities, the *Code of Virginia* in Title 63.1 provides that a resident may be "discharged only when provided with a statement of reasons, or for nonpayment for his stay and is given reasonable advance notice...." Department of Social Services (DSS) licensing standards regarding admission and retention require that resident notification will be given at least 14 calendar days prior to the date of discharge including discharge due to the facility's voluntary closure.
- DSS indicated that 198 assisted living facilities in Virginia closed or changed ownership from FY 1997 through FY 2000. While DSS tracks closures for licensing purposes, little information regarding the

circumstances of the closures is automated. DSS estimated that 80 percent of the closures were voluntary in nature.

- HB 1920 and SB 845 were introduced at the request of the Jefferson Area Board for Aging (JABA). JABA staff expressed concerns regarding the adequacy of resident protections when a long-term care facility decides to voluntarily close. JABA staff assisted in the closing of Jefferson Park Center during the summer of 2000. Jefferson Park Center representatives established a 90-day timeframe for relocating all residents and subsequently closing. JABA staff indicate that the 90-day timeframe did not allow for sufficient time for Jefferson Park Center residents to make an informed choice as to where to move. In addition, concern was expressed that Jefferson Park Center residents were encouraged to transfer to Oak Hill, a facility which was owned by the same parent company. Oak Hill had been cited in March 2000 and again in June 2000 by VDH for deficiencies related to federal certification requirements. All deficiencies were corrected by August of 2000.

- Both VDH and Department of Medical Assistance Services (DMAS) staff indicated that they were not aware of any problems occurring during the closing of Jefferson Park Center and that no complaints were received from residents or their families regarding the closure. VDH and DMAS staff indicated that they would not favor additional statutory requirements as adequate resident protections are provided by federal regulations and because limited financial resources are typically available to the closing facility.

- DSS staff indicated that while they were not aware of problems during the closing of Jefferson Park Center's assisted living facility, a number of closures have been quite problematic. DSS staff indicated that the provisions of HB 1920 and SB 845 generally do not address the problems of assisted living facility closures and that in some cases the bill provisions may exacerbate the problems. DSS staff stated that it is often best to move assisted living residents as quickly as possible to ensure that their quality of care does not suffer.

- Industry representatives also indicated concerns about the bills' provisions. One concern was that new statutory requirements could provide new grounds for lawsuits and negatively affect the cost and availability of liability insurance. A second concern was that a facility closing due to financial problems would not have the resources to provide quality care and remain open at low resident capacities.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 37 and 38. Public comments were solicited on the draft report. A summary of the public comments is attached at Appendix D.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Jefferson Area Board for Aging, the Virginia Department of Health, the Department of Medical Assistance Services, the Department of Social Services, the Office of the State Long-Term Care Ombudsman and the other agencies and associations who provided input and information during this study.

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January 2002

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I.
Authority for the Study

House Bill (HB) 1920 and Senate Bill (SB) 845 of the 2001 General Assembly Session, as introduced, provided statutory requirements and resident protections that would apply to long-term care facilities which choose to voluntarily close or "not to renew its license or Medicare or Medicaid provider agreement...." The two identical bills included statutory requirements providing for written notification at least 120 days prior to the intended date of closure, the formation of relocation teams, and the appointment of receivers for non-compliant facilities.

HB 1920 was left in the House Committee on Health, Welfare and Institutions; SB 845 was left in the Senate Committee on Education and Health. The House Committee on Health, Welfare and Institutions agreed to refer HB 1920 to the Joint Commission on Health Care (JCHC) for further study. The Senate Committee on Education and Health approved a motion to refer the issues presented in SB 845 for consideration by JCHC's Long-Term Care Subcommittee. The letter from the chairman of the Senate Committee on Education and Health states:

> "The Long-Term Care Subcommittee is asked to examine SB 845 in relationship to the many issues it presents, including, but not limited to (i) timely notice to residents, their relatives or other legal representatives, of the intent to close a facility or not renew a license or provider agreement; (ii) planning for relocation of the residents vis-à-vis availability of and access to other facilities and needed health services; (iii) adequate notice to and input from other local or regional health care providers concerning the pending relocation of residents; (iv) adequate information on the geographic distribution of relocation facilities and the travel and transportation implications for residents, their relatives or other legal representatives; (v) realistic information on the physical condition, accommodations, and services of the proposed relocation facilities and the availability of needed health services near the facilities; (vi) adequate consideration of the personal desires and needs of the residents, their relatives or other legal representatives; and (vii) provision of options and choices for relocation to the residents, their relatives or other legal representatives."

A copy of this letter is included in Appendix A. HB 1920 and SB 845, as introduced, are included in Appendix B.

An Amendment in the Nature of a Substitute Represents the Form of the Bill to Be Considered in the Study

An amendment in the nature of a substitute was drafted for HB 1920 but was not formally adopted. However, the patrons of HB 1920 and SB 845 asked that the provisions of the substitute bill be considered in completing this study as opposed to the provisions of the bills as introduced. The statutory provisions of the substitute generally require:

- a long-term care facility to provide written notification of its plan to close at least 60 days in advance of the intended closure date;
- written notification to go to the state licensing agency (either the Department of Health or the Department of Social Services), facility residents and their authorized representatives and physicians;
- consultation on the part of the licensing agency with other state agencies (including the Departments of Social Services or Health; Medical Assistance Services; Mental Health, Mental Retardation and Substance Abuse Services; and Aging) and the Office of the State Long-Term Care Ombudsman to ensure the health and safety of residents; and
- a state petition to the circuit court to appoint a receiver if the facility fails to comply with statutory requirements.

A copy of the amendment in the nature of a substitute for HB 1920 is included in Appendix C.

Organization of Report

This report is presented in four major sections. This section discusses the authority for the study. Section II discusses characteristics and regulation of long-term care facilities. Section III discusses resident protections during voluntary closures of long-term care facilities. Section IV provides a series of policy options the Joint Commission on Health Care may wish to consider in addressing the issues raised in this study.

II.
Characteristics and Regulation of Long-Term Care Facilities

Long-term care facilities are generally considered to include residential care facilities ranging from community-based facilities such as independent living and assisted living facilities to institutional care provided in nursing facilities. In Virginia, community-based long-term care facilities are typically regulated by the Department of Social Services (DSS) and institutional long-term care facilities by the Virginia Department of Health (VDH). (The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) licenses its treatment facilities under authority that is separate from that of nursing or assisted living facilities. Since HB 1920 and SB 845 recommend changes that would only apply to nursing and assisted living facilities, DMHMRSAS facilities have not been considered in completing this study. Moreover, considerable restrictions on the closure of DMHMRSAS facilities are already in place. The 2000-2002 Appropriations Act requires DMHMRSAS to complete impact analyses and to receive approval from the General Assembly before any facility it operates is "sold, privatized, closed, or converted.")

Nursing facilities have a long history in this country. Generally nursing facilities provide 24-hour nursing care that is either less intensive or more long-term than a hospital typically provides or that is more specialized than most institutions offer. A nursing facility may choose to meet only the regulatory requirements established by an individual state; however, in order to receive Medicaid or Medicare funding the nursing facility would also need to meet federal certification requirements. The majority of nursing facilities seeks federal certification, as Medicaid is the primary source of payment for 70 percent of nursing facility residents in the United States.

In contrast with nursing facilities, assisted living facilities are a relatively new and more varied form of long-term care. Assisted living facilities range from board and care homes that provide basic services such as medication management to facilities that provide care in a home-like, "normalized" environment for individuals who actually qualify for nursing home care. Unlike nursing facilities, there are no federal regulations for

assisted living. While all states regulate facilities that provide assisted living, states differ in how they define what constitutes assisted living and the name used to designate these facilities. Consequently, the manner in which assisted living is regulated and funded differs from state to state.

Given the significant differences in how nursing and assisted living facilities are operated, regulated, and funded, the impact of the statutory provisions contained in House Bill 1920 and Senate Bill 845 will be reviewed separately for nursing facilities and assisted living facilities in Virginia.

Nursing Facilities in Virginia Are Generally Highly Regulated, Relatively Large Facilities Which House a Number of Public Pay Residents

In Virginia, all nursing facilities must be licensed by the Virginia Department of Health (VDH). In addition, nursing facilities that want to participate in the Medicare or Medicaid programs must be certified by VDH as meeting the certification requirements of the Health Care Financing Administration (HCFA) of the U. S. Department of Health and Human Services. State licensure standards for nursing facilities are relatively modest when compared with HCFA regulations for participation in Medicare and Medicaid. VDH reported that as of March 2001, there were 267 nursing facilities in Virginia with 30,328 licensed beds. More than 90 percent or 248 of those nursing facilities were certified to receive Medicaid and/or Medicare funding.

In Virginia, nursing facilities are also subject to Certificate of Public Need (COPN) provisions which restrict the number of facilities and licensed beds that may be constructed. COPN provisions assist in ensuring a higher occupancy rate for nursing facilities by controlling the inventory of beds. Figure 1 illustrates the number of licensed beds that were located within 246 nursing facilities. (Note that while all nursing facilities are required to report certain information to VDH, some reports were not received in time to have their information included in the 2000 report.) Nursing facilities tend to be relatively large facilities. As Figure 1 shows, only 14 percent of nursing facilities were licensed for 50 or fewer beds and a number of these smaller facilities were long-term care units that operate within another type of facility such as a hospital. More than one-half of nursing facilities were licensed for more than 100 beds. The actual number of licensed beds ranged from eight to 373 beds.

Figure 1

Number of Licensed Beds in Virginia's Nursing Facilities

Licensed Beds	Number of Nursing Facilities	Percentage of Total
0 - 50 beds	34	14
51-100 beds	74	30
101 - 150 beds	75	31
151- 200 beds	45	18
201 or more beds	18	7
Total	**246**	**100**

Source: Virginia Health Information publication, *The 2000 Industry Report: Virginia Hospitals and Nursing Facilities.*

Current Protections Regarding Discharge by Nursing Facilities Are Established in Federal Regulation and State Statute and Regulation

As noted previously, nursing facilities in Virginia are required to have a state license and may choose to seek federal certification (in order to receive Medicare or Medicaid reimbursement). Virginia has established both statutory and regulatory provisions which apply to nursing facilities. Protections for residents during facility closures are provided indirectly through both federal and state requirements which address resident transfers and discharges. In addition, state statutes directly provide protections for nursing facility residents during facility closures. These federal and state requirements are summarized in Figure 2 and discussed in more detail in subsequent sections.

Federal Regulations: Federal certification for nursing facilities provides resident protections from unnecessary or abrupt transfers and discharges. These provisions are found in the *Code of Federal Regulations* Title 42: Chapter IV, Sec. 483.12. (This section of the federal *Code* defines transfer and discharge as "movement of a resident to a bed outside of the certified facility whether the bed is in the same physical plant or not.") Relevant portions of this section are contained in Figure 3. As noted, federal regulations restrict the circumstances in which a resident may be involuntarily transferred or discharged to include instances of facility closure. These federal regulations also state that written notice is to be given to residents, their families, and any legal representatives at least 30 days in advance of transfer or discharge except in emergency situations.

Figure 2

Federal and State Requirements Which Provide Resident Protections in the Event of Nursing Facility Closure

Source of Requirement	Requirement Application	Provisions of Requirement
Code of Federal Regulations Title 42: Chapter IV, Sec. 483.12.	Nursing Facilities Certified to Receive Medicare and Medicaid	Nursing facility residents may not be involuntarily transferred or discharged except under certain circumstances (including that the facility closes). **Residents are to be given at least 30 days notice** prior to being transferred or discharged, except in certain emergency situations.
Code of Virginia § 32.1-27.1.B	Licensed and Certified Nursing Facilities	The Commissioner of Health is granted authority to **petition the circuit court to have a receiver appointed** to operate a nursing facility if the nursing facility: (i) is in jeopardy of losing its state license or federal certification; (ii) is in jeopardy of losing its provider agreement from the U. S. Department of Health and Human Services or from DMAS; (iii) **has given VDH less than 90 days prior notice of its intention to close** or to relinquish its license or provider agreement; (iv) is operating in a manner that presents "a major or continuing threat to the health, safety, security, rights or welfare of the patients, including the threat of imminent abandonment by the owner or operator, or a pattern of failure to meet ongoing financial obligations such as the inability to pay for essential food, pharmaceuticals, personnel, or required insurance; or (v) **the Department [of Health] is unable to make adequate and timely arrangements for relocating all patients who are receiving medical assistance**...to ensure their continued safety and health care."
Code of Virginia § 32.1-138.1	Licensed Nursing Facilities	Nursing facility residents may not be involuntarily transferred or discharged except under certain circumstances. **Residents are to be given "reasonable advance written notice" prior to being transferred or discharged** (except in certain emergency situations). Advance notice is subsequently defined to be at least five days in the case of involuntary transfer or discharge.
VDH Regulations for the Licensure of Nursing Facilities -- 12VAC5-371-40	Licensed Nursing Facilities	Nursing facilities must submit **written notification to VDH, 30 working days prior to any proposed changes** to their facility licenses.

Source: JCHC staff analysis of federal and state requirements of certified and licensed nursing facilities.

Figure 3
***Code of Federal Regulations* Title 42: Chapter IV, Sec. 483.12.**

Sec. 483.12. Admission, transfer and discharge rights.

(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless --

(i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(ii) The transfer or discharge is appropriate because the resident's health has improv-ed sufficiently so the resident no longer needs the services provided by the facility;

(iii) The safety of individuals in the facility is endangered;

(iv) The health of individuals in the facility would otherwise be endangered;

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility....or

(vi) The facility ceases to operate.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility must --

(i) Notify the resident, and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

(ii) Record the reasons in the resident's clinical record; and

(iii) Include in the notice the [reasons for the transfer or discharge]....

(5) Timing of the notice. (i) Except when specified in paragraph (a) (5) (ii) of this section, the notice of transfer or discharge required under paragraph (a) (4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice may be made as soon as practicable before transfer or discharge when --

(A) The safety of individuals in the facility would be endangered under paragraph (a) (2) (iii) of this section;

(B) The health of individuals in the facility would be endangered, under paragraph (a) (2) (iv) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a) (2) (ii) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a) (2) (i) of this section; or

(E) A resident has not resided in the facility for 30 days.

(6) Contents of the notice. The written notice specified in paragraph (a) (4) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement that the resident has the right to appeal the action to the State;

(v) The name, address and phone number of the State long term care ombudsman;

(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals...and

(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals....

(7) Orientation for transfer or discharge. A facility must provide sufficient preparation and orientation to residents to ensure a safe and orderly transfer or discharge from the facility.

State Requirements: As was noted in Figure 2, state statutes and licensing regulations both directly and indirectly provide protections for residents during a nursing facility closure. *Code of Virginia* § 32.1-27.1B addresses the circumstances in which the Health Commissioner is granted authority to request the appointment of a receiver. The Commissioner is authorized to petition the circuit court to appoint a receiver for a nursing facility under the following circumstances: (1) the nursing facility has given VDH less than 90 days notice of its intention to close or relinquish its license or provider agreement, (2) the facility is operating in an unsafe manner, or (3) the facility has provided VDH with insufficient time to "make adequate and timely arrangements for relocating all patients...[who receive Medicare or Medicaid] to ensure their continued safety and health care." As indicated, it is left to the Commissioner's discretion as to whether to petition the circuit court in these circumstances.

Figure 4 includes the provisions of *Code of Virginia* § 32.1-138.1. which provides resident protections related to involuntary transfer and discharge from a nursing facility. This *Code* section first addresses resident (or patient) protections related to involuntary transfer or discharge. As noted, a resident may not be involuntarily transferred or discharged except to address medical needs, to provide protection for the resident or for other residents, for non-payment for care, or with "informed voluntary consent...following reasonable advance written notice." Advance notice is subsequently defined in *Code* § 32.1-138.1C. to be at least five days in the case of involuntary transfers or discharges and to be "reasonable under the circumstances" for voluntary transfers or discharges. The *Code* section further requires that "except in an emergency involving the patient's health or well being," the patient (resident) and his family or responsible party and physician must be consulted prior to transfer or discharge.

State licensing standards in 12VAC5-371-40 require nursing facilities to provide VDH written notification of any intent to modify their licenses "30 working days in advance of any proposed changes...." A closure involves relinquishing the facility license and as such is a modification of the facility's license. This requirement provides for advance notice of a facility's intention to close allowing VDH to coordinate with other agencies such as DMAS to allow for an orderly transition. To date, however, no nursing facility has alerted VDH of plans to close prior to making a general announcement to residents and their families.

Figure 4
***Code of Virginia* § 32.1-138.1**

§ 32.1-138.1. Implementation of transfer and discharge policies.

A. To implement and conform with the provisions of subdivision A 4 of § 32.1-138, a facility may discharge the patient, or transfer the patient, including transfer within the facility, only:

1. If appropriate to meet that patient's documented medical needs;

2. If appropriate to safeguard that patient or one or more other patients from physical or emotional injury;

3. On account of nonpayment for his stay except as prohibited by Titles XVIII or XIX of the United States Social Security Act and the Virginia State Plan for Medical Assistance Services; or

4. With the informed voluntary consent of the patient, or if incapable of providing consent, with the informed voluntary consent of the patient's authorized decision maker pursuant to § 54.1-2986 acting in the best interest of the patient, following reasonable advance written notice.

B. Except in an emergency involving the patient's health or well being, no patient shall be transferred or discharged without prior consultation with the patient, the patient's family or responsible party and the patient's attending physician. If the patient's attending physician is unavailable, the facility's medical director in conjunction with the nursing director, social worker or another health professional, shall be consulted. In the case of an involuntary transfer or discharge, the attending physician of the patient or the medical director of the facility shall make a written notation in the patient's record approving the transfer or discharge after consideration of the effects of the transfer or discharge, appropriate actions to minimize the effects of the transfer or discharge, and the care and kind of service the patient needs upon transfer or discharge.

C. Except in an emergency involving the patient's health or well being, reasonable advance written notice shall be given in the following manner. In the case of a voluntary transfer or discharge, notice shall be reasonable under the circumstances. In the case of an involuntary transfer or discharge, reasonable advance written notice shall be given to the patient at least five days prior to the discharge or transfer.

D. Nothing in this section or in subdivision A 4 of § 32.1-138 shall be construed to authorize or require conditions upon a transfer within a facility that are more restrictive than Titles XVIII or XIX of the United States Social Security Act or by regulations promulgated pursuant to either title.

Very Few Nursing Facilities in Virginia Have Closed in Recent Years

VDH staff reported that very few nursing facilities have closed in Virginia in recent years. No nursing facility has been closed involuntarily

due to certification or licensing issues in the last eight years. Instead, VDH, in concert with the Office of the Attorney General (OAG), has been able to work with seven facilities whose federal certification was in jeopardy to address the problems.

Figure 5 summarizes information provided by VDH regarding the ten voluntary closures and relocations that have occurred in the last four years. Although relocations are somewhat different from a facility closing, relocations were included in an effort to define "closing" in a broad manner. Facility relocations typically involve the opening of a new or expanded facility into which residents of a facility that is being closed may move. It should be noted that nursing facility residents generally have the right to move at any time into any nursing facility which has an available bed, can provide the level or type of care the resident needs, and accepts the form and amount of payment the resident offers.

As shown, six of the ten facility changes shown in Figure 5 involved relocating residents to a new or expanded facility rather than the loss of nursing facility beds. Moreover, one of the four closings involved a 27-bed care unit within a hospital rather than a freestanding facility. The three freestanding facilities that closed included 361 licensed beds.

Assisted living facilities are not subject to COPN provisions meaning that there has been no control exerted by the Commonwealth over the number of facilities that operate in the state. In Virginia, the number of licensed assisted living beds has increased by almost 50 percent from 22,538 in 1990 to 33,505 in 2000. Figure 6 illustrates the number of licensed beds contained in Virginia's 615 assisted living facilities. As Figure 6 shows, almost 70 percent of the facilities have 50 or fewer licensed beds while only seven percent have more than 100 licensed beds. The smallest licensed assisted living facilities have four licensed beds and the largest facility has 610 licensed beds.

Assisted Living Facilities in Virginia Include a Number of Relatively Small Facilities and Serve More Private than Public Pay Residents

In Virginia, assisted living facilities range from small board and care type facilities to large facilities that provide extensive support services. Any residential care facility which meets Virginia's statutory definition of

Figure 5

Voluntary Nursing Facility Closings and Relocations 1997 to Present

Facility	Location	Licensed Beds	Type of Action
Roanoke City Nursing Home	Roanoke	58	Relocation to Pheasant Ridge
Staunton Manor Nursing Home	Staunton	89	Relocation to Augusta Nursing and Rehabilitation
District Home	Warrenton	117	Relocation to King's Daughter Community Health and Rehabilitation
Wheatland Hills Retirement Center	Radford	24	Closed
Park View Nursing and Rehabilitation Center	Portsmouth	164	Closed
James Point Care Center	Newport News	192	Relocation of 102 residents to Newport News Nursing and Rehabilitation and 90 to Tandem of Williamsburg
Jefferson Park Center	Charlottesville	173	Closed
Shenandoah Memorial Hospital	Woodstock	34*	Relocation to Tandem Health of Woodstock
Susan B. Miller Nursing Home	Woodstock	54	Relocation to Tandem Health of Woodstock
Carillion New River Valley Hospital	Radford	27*	In the process of closing

* These beds are part of a hospital unit rather than a freestanding nursing facility.

Source: JCHC staff analysis of information provided by the Virginia Department of Health.

assisted living facility is required to be licensed by DSS. *Code of Virginia* § 63.1-172 defines an assisted living facility as "any congregate residential setting that provides or coordinates personal and health care services, 24-hour supervision, and assistance (scheduled and unscheduled) for the maintenance or care of four or more adults who are aged, infirm or disabled...." The *Code* provides for four types of exemptions from this licensing requirement: (1) facilities that are licensed by VDH or the

Department of Mental Health, Mental Retardation and Substance Abuse Services; (2) homes in which a caregiver only cares for "persons related to him by blood or marriage;" (3) child-caring institutions licensed by DSS; and (4) housing projects for the elderly or disabled that provide "no more than basic coordination of care services" and are funded by the U. S. Department of Housing and Urban Development, the U. S. Department of Agriculture or the Virginia Housing Development Authority. The Board of Social Services is statutorily authorized in *Code of Virginia* § 63.1-174 to "promulgate and enforce regulations to...protect the health, safety, welfare and individual rights of residents of assisted living facilities...."

Figure 6

Number of Licensed Beds in Virginia's Assisted Living Facilities

Licensed Beds	Number of Facilities	Percentage of Total
0 - 50 beds	428	69
51-100 beds	147	24
101 - 150 beds	4	1
151- 200 beds	11	2
201 or more beds	25	4
Total	**615**	**100**

Source: Department of Social Services.

In Virginia, state funding in the form of an auxiliary grant is provided to assist low-income individuals who need assisted living due to physical and/or mental impairment. The maximum auxiliary grant rate is currently $815 per month for most of the state and $937 per month for the Northern Virginia region. Approximately 430 of Virginia's 615 assisted living facilities have been approved to receive auxiliary grant payments. However, that does not mean that these 430 facilities are actively admitting residents who receive the auxiliary grant. Some facilities will accept a limited number of residents who receive the auxiliary grant or will allow residents who can no longer pay the private care rates to remain at the auxiliary grant rate. Approximately one-fifth of assisted living residents receive an auxiliary grant.

Protections Regarding Resident Discharge by an Assisted Living Facility Are Established in Statute and Regulation; However, These Protections Are Not as Specific as Those for Nursing Facilities

There is no statutory provision that provides specific protections for assisted living residents when a facility closes. *Code of Virginia* § 63.1-182.1 delineates general rights and responsibilities that are to be afforded residents of assisted living facilities. The objective of the statutory language addressing resident discharges is to protect residents against arbitrary or abrupt discharge from an assisted living facility. Section 63.1-182.1 states that a resident is "discharged only when provided with a statement of reasons, or for nonpayment for his stay, and is given reasonable advance notice; upon notice of discharge or upon giving reasonable advance notice of his desire to move, shall be afforded reasonable assistance to ensure an orderly" discharge. "Reasonable advance notice" is not specifically defined in Title 63.1 of the *Code*.

There is no DSS licensing provision that specifically addresses time frames for the notice that is to be given prior to assisted living facility closure. DSS *Standards and Regulations for Licensed Adult Care Residences* include provisions for general admission and retention policies. (DSS standards still refer to "adult care residences" rather than "assisted living facilities" because emergency standards which would incorporate the statutory changes made during the 2000 General Assembly session have not yet been adopted by the Board of Social Services.) The primary focus of these DSS standards is to prevent individuals who cannot be properly cared for within the assisted living facility from being admitted or retained within the facility. Thus, the standards emphasize the need for the facility to be able to properly care for all residents and delineate limitations in the types of conditions that residents may have. For example, residents who are dependent on ventilators or require "continuous licensed nursing care" cannot reside in an assisted living facility. Sec. 22 VAC 40-71-160.B of the DSS standards addresses resident discharge, and provides that the facility shall "notify the resident and the resident's personal representative, if any, of the planned discharge. The notification shall occur at least 14 calendar days prior to the actual discharge date." This 14-day requirement applies to facility "discharges" that occur because the facility is closing.

Definitive Information Regarding Recent Closures of Assisted Living Facilities Is Not Available

Although assisted living facility closures are tracked by DSS for licensing purposes, relatively little information regarding the circumstances of these closures is automated. DSS staff indicated that many of the "closures" actually involve changes in ownership which do not require any residents to move from the facilities. DSS was not able to provide information regarding the number of assisted living facility closures that involved ownership changes, the location of the facilities that closed, or the number of licensed beds that were affected by the closures.

Figure 7 includes the information DSS provided regarding the number of assisted living facilities that closed or changed ownership since 1997 and the number that were considered by DSS to be voluntary closures. DSS figures indicate that an average of 50 facilities closed each year with 80 percent of the closures being voluntary in nature. DSS staff also stated that very few of these closures required DSS staff to become involved at the facility-level to assist in appropriately relocating the residents.

Figure 7

Number of Assisted Living Facility Closures in Virginia
FY 1997 to FY 2000

Fiscal Year	Number of Voluntary Closures	Total Number of Closures
1997	36	41
1998	38	51
1999	45	53
2000	39	53
Total	**158**	**198**

Source: Department of Social Services.

Three regional DSS licensing administrators were contacted in order to get specific information regarding assisted living facility closures that they were aware of during the last year. In the Eastern region, ten facilities chose to no longer be licensed by DSS. Six of the ten "closures" involved no residents moving from the facilities -- three facilities converted to being licensed through the Department of Mental Health, Mental Retardation

and Substance Abuse Services, two facilities changed ownership, and one facility had only three residents and no longer had to be licensed. The four remaining facilities were all small facilities housing between three and 15 residents each at the time of closure. One facility (three residents) was part of a nursing facility and the three assisted living beds were converted into nursing facility beds. Two facilities closed -- one (six residents) because the property was sold for another use and one (15 residents) because the owner retired from the business. The final facility (12 residents) closed due to financial and licensing compliance problems. In the Central region, only one facility voluntarily closed (two residents) due to ongoing licensing compliance problems. In the Piedmont region, two facilities were voluntarily closed. The first facility which closed due to ongoing licensing compliance problems allowed six weeks to relocate 120 residents. The second facility which converted its beds into independent living beds allowed 60 days to relocate 45 residents. The licensing administrator for the Piedmont region indicated that the relocations went well and the facilities had no problems meeting their self-imposed timeframes.

A Number of State and Local Entities May Become Involved in Assisting in Long-Term Care Facility Closures

Figure 8 describes the responsibilities that state and local entities generally assume when long-term care facilities close. DMAS staff assume the primary role of assisting with the relocation of nursing facility residents who receive Medicaid. DMAS would also assist in relocating any resident who receives intensive assisted living services within an assisted living facility. Quality of care and compliance with regulatory standards are monitored by VDH for nursing facilities, by DSS for assisted living facilities, and by DMHMRSAS for its treatment facilities. Adult protective services staff at both the state and local level assist residents of nursing and assisted living facilities if those residents are considered to be at risk of being discharged without having an appropriate placement arranged. Thus, residents who have good family support and assistance probably would not need APS assistance. Conversely, a resident who has little family support and was not capable of finding another facility would require APS assistance. Ombudsman staff are also available to provide support and assistance to residents when a facility is closing. Ombudsman staff may also advise regulatory staff of problems with quality of care or compliance with regulatory standards as the facility is closing.

Figure 8

Responsibilities of State and Local Entities in Assisting with Facility Closures in Virginia

State Entity	Primary Responsibilities
Department of Medical Assistance Services	The Medicaid staff provide assistance as needed to relocate nursing facility residents who receive Medicaid and to relocate assisted living residents who previously received the Medicaid waiver for the intensive assisted living supplement.
Virginia Department of Health	The regulatory staff ensure that quality of care and regulatory standards continue to be maintained by nursing facilities during the transition and that relocations are made in an appropriate manner that considers the preferences of the resident and family.
Virginia Department of Social Services	The licensing staff ensure that quality of care and regulatory standards continue to be maintained by assisted living facilities during the transition and that relocations are made in an appropriate manner that considers the preferences of the resident and family.
	Adult Protective Services staff provide assistance as needed to relocate nursing and assisted living facility residents who are at risk of being discharged without having an appropriate residential placement arranged.
Virginia Department of Aging	Staff are primarily available as resources regarding long-term care alternatives including the types of facilities and support services that are available in the community.
Department of Mental Health, Mental Retardation and Substance Abuse Services	Regulatory staff ensure that quality of care and regulatory standards continue to be maintained by facilities regulated by DMHMRSAS. Programmatic staff assist in notifying residents and their families and in ensuring that residential placements offer needed services. Programmatic and Human Rights staff also work with residents and their families after relocation to ensure that the placement is appropriate.
Local Entity	**Primary Responsibilities**
Local Departments of Social Services	Adult Protective Services staff provide assistance as needed to relocate nursing and assisted living facility residents who are at risk of being discharged without having an appropriate residential placement arranged.
State and Local Ombudsman Offices	Ombudsman staff act as resources to residents in exploring and understanding their rights and options regarding relocation, and in advising residents regarding what to look for in choosing a new facility. Ombudsman staff also observe quality of care and compliance with regulatory standards as the facility is closing.
Area Agencies on Aging	Level of involvement varies according to the resources of the local agency. Area agencies can be particularly helpful in identifying resources such as Meals on Wheels and in-home care for individuals who want community-based care.
Community Service Boards	Staff provide assistance as needed to assure services for nursing home and assisted living facility residents who have diagnosed mental health/mental retardation needs and who are at risk of being discharged without having appropriate residential placements and services arranged.

Source: JCHC staff analysis.

III.
Consideration of Resident Protections During Voluntary Closures of Long-Term Care Facilities

Concerns Related to the Experiences of Residents During a Recent Closure in Charlottesville Led to the Request for Legislation (HB 1920, SB 845) During the 2001 General Assembly Session

Staff within the Jefferson Area Board for Aging (JABA), the area agency on aging for the Charlottesville area, were very involved during the closing of Jefferson Park Center during the summer of 2000. JABA staff indicated that concerns regarding the relocation of Jefferson Park Center residents led them to request legislation to provide enhanced resident protections during voluntary closures of long-term care facilities.

JABA staff indicated that the primary objective in requesting the introduction of HB 1920 and SB 845 was to ensure that when a long-term care facility decides to close, the residents of that facility are allowed sufficient time to make an informed choice regarding where they are going to move. JABA staff stated that the timeframe provided for relocating residents during the closing of Jefferson Park was not sufficient to adequately inform and assist residents in moving. JABA staff also indicated they were concerned because it appeared that residents were encouraged to transfer to a nursing facility that had received a substandard certification survey by VDH in March 2000. The nursing facility, Oak Hill Center, was operated by Genesis Health Ventures which also operated Jefferson Park Center.

Jefferson Park Center Opened in 1996 and Included a Nursing Facility and an Assisted Living Facility

Jefferson Park Center was one of seven long-term care facilities Genesis Health Ventures operated in Virginia. (Genesis Health Ventures is based in Pennsylvania and operates more than 300 long-term care facilities in 15 states.) Jefferson Park Center included nursing and assisted living sections with licensed capacities of 173 nursing beds and 59 assisted living beds. Jefferson Park occupied a six-story building that was located one block from the University of Virginia hospital. The building had served as

a nursing facility since 1971 and was operated by a number of companies prior to its purchase by Genesis in 1996.

In explaining the closing of Jefferson Park Center, a representative of Genesis Health Ventures stated that the facility required extensive physical plant improvements that were made over the four years that Genesis operated the facility. Within months of opening, Jefferson Park Center was cited by the Virginia Department of Health for deficiencies. VDH denied payment to Jefferson Park for new Medicare and Medicaid residents for approximately six months. The sanction was lifted after substantial physical plant and operational improvements were made by Jefferson Park. The Genesis representative indicated that Jefferson Park never recovered financially from the sanctions that were imposed and the low reimbursement received for Medicare and Medicaid residents. In a statement released on June 5, 2000, a Genesis representative stated,

> "Although it is a tough decision to close a center, Jefferson Park's low Virginia Medicaid reimbursement rate -- less than $3 per hour -- plus drastic cuts in Medicare spending have negatively impacted the financial health of the center. Those factors, coupled with a tight job market which makes it hard to attract qualified nursing staff, were key in the decision to close."

In June 2000, Genesis officials estimated annual losses of $1 million were incurred by Jefferson Park Center.

Jefferson Park Center Developed a Relocation Plan and Staff Severance Package to Facilitate the Closing

At the time that the closing of Jefferson Park Center was announced, the facility housed a total of 134 residents (32 of whom were assisted living residents). Genesis representatives indicated that a relocation plan was submitted to VDH prior to the announced closing and that ongoing updates were distributed. All facility staff were offered severance packages that were dependent on staff continuing to work until Genesis released them. Genesis representatives indicated that the severance packages did allow Jefferson Park to maintain its staff and to properly care for all residents until they could be relocated. In addition, 24 staff from Jefferson Park were eventually transferred to other Genesis facilities.

Jefferson Park residents were also granted priority status in terms of being admitted into other Genesis facilities. Of the 134 residents who were relocated, 47 or 35 percent moved to another Genesis facility. Thirty-two of those residents moved into Oak Hill Center which is located in Staunton approximately 35 miles from Charlottesville. As noted previously, Oak Hill had received a substandard compliance report in March 2000.

March 2000 Survey of Oak Hill Identified Substandard Compliance with Certification and Licensing Standards: In March 2000, VDH completed an unannounced inspection of Oak Hill Center. Oak Hill was subsequently cited for deficiencies related to federal certification requirements in the areas of staff treatment of residents, resident assessment, quality of care, nursing services, and physical environment. A number of the deficiencies involved substandard resident care including the following case:

> An 81 year-old male resident with many chronic medical conditions was admitted to Oak Hill following surgery for a hip and an arm fracture. The medications that had been ordered for the resident were not given for at least one day and the resident's vital signs were not routinely monitored. Eight days following admission to Oak Hill, the resident was taken to a hospital emergency room where he died from "sepsis [a toxic condition] secondary to pneumonia and cardiac arrest."

Oak Hill was also cited for being non-compliant with VDH licensing regulations including failing to provide a tub or shower bath to each resident at least twice a week and failing to complete criminal records checks within 30 days of retaining eight of 25 employees that were hired.

VDH conducted a "revisit survey" on June 2, 2000. HCFA, in a letter to Oak Hill in late June, indicated that VDH's revisit found "the most serious deficiency in your facility to be an isolated deficiency that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy." The letter also indicated, however, that Oak Hill's failure to achieve full compliance with federal certification standards would result in HCFA's denial of Medicare and Medicaid payments for any new admission to Oak Hill beginning July 8, 2000. (If Oak Hill had failed to achieve full compliance prior to September, its Medicare and Medicaid provider agreement would have been terminated effective September 1, 2000.) VDH conducted another "revisit survey" on August 1,

2000 and determined that Oak Hill had corrected all deficiencies. On August 18, 2000, HCFA rescinded its denial of payment. VDH staff stated that Oak Hill has been visited twice since August and no serious deficiencies were cited.

The Key Concerns of JABA Staff Were the Timeframe Allowed for Relocating Residents and the Transfer of Residents to an Affiliated Nursing Facility

As noted previously, JABA staff indicated that the timeframe allowed for relocating Jefferson Park residents did not provide enough time to adequately explore their housing options. Moreover, concern was expressed regarding whether Jefferson Park residents were being encouraged to transfer to Oak Hill without being told about the compliance problems the facility had experienced.

Jefferson Park Center representatives indicated that it was their intention to relocate all residents within 90 days of the announced closing. The last resident was relocated on July 18th, 42 days after the closure was announced. JABA staff indicated that this short timeframe contributed to the following:

- a relocation interview that consisted of a two-minute conversation between a Jefferson Park Center staff member and a resident regarding the resident's preferences for a new facility,
- a resident being moved into a facility space that had been secured for another family member after being told by a Jefferson Park social worker that staff were having trouble relocating residents because there were no vacancies locally, and
- a resident who wanted to be evaluated to live in the community but was "moved to another nursing home not of her choice" because home care screening could not be arranged before she had to move out of Jefferson Park Center.

JABA staff indicated that they believe these difficulties could have been avoided if a longer period of time had been provided for assisting residents in choosing a new place to live.

The local ombudsman completed a follow-up report of the closure of Jefferson Park Center which found that 68 residents moved out of Planning District 10, 54 residents moved to another facility within the planning

district, and eight residents returned home. The summary continued in stating:

> "Although the majority of these relocated residents report being satisfied and some even happy in their new homes, follow-up with several residents has revealed the need for multiple collateral contacts and mediation services...[as well as] resident requests to assist in locating alternate housing."

Some of the relocation problems reported by the ombudsman included:

- a resident whose dementia precludes her from using utensils when eating was served food that had not been cut up or blended for easy consumption,
- a resident who had a private room in Jefferson Park was relocated to a facility where he had two roommates resulting in a request to be moved again to another facility,
- a resident who needed to be closely monitored as she believes that her late husband and her former roommate are still living in Jefferson Park, and
- an assisted living facility resident who was very independent and enjoyed going places such as the store and library but was moved to an unfamiliar rural area with fewer places to visit.

A Genesis official was asked about the compliance problems Oak Hill experienced during the six-month period between February 2000 and July 2000. The official indicated that facility administration was lacking during the early months of 2000 but personnel action was taken and the operational problems were addressed. It is the opinion of the Genesis official that the problems that had been experienced were isolated incidents and were not representative of Oak Hill's operation over time. The official stated that by the time Jefferson Park Center announced its intention to close, all of the most serious compliance problems had been addressed and that the survey conducted June 2, 2000 was discussed with potential residents at their request. Nursing facility residents have the right, under the federal *Nursing Home Reform Act*, to review survey reports completed on any nursing facility.

Virginia Department of Health Staff Were Not Aware of Problems During the Closing of Jefferson Park Center

During interviews with JCHC staff, VDH staff indicated that they were not aware of any problems occurring during the closing of Jefferson Park Center. VDH staff indicated that Jefferson Park officials were very forthcoming in announcing the closure and in developing a relocation plan. VDH staff reviewed the relocation plan and considered it to be reasonable and well-developed. The relocation plan included descriptions of the following procedures that would be arranged or completed by Jefferson Park staff:

- Verbal and written notification of closing to residents, residents' families and/or legal representatives, and residents' health care providers (physicians, dentists, etc.).
- Resident assessments including pre-admission screenings, medical coverage determinations, medical and social assessments, and psychological preparation and counseling.
- Family meetings that include residents, family members, legal representatives, and state agency representatives.
- Identification of available beds, pre-admission visits, and placement assistance.
- Resident transfers of no more than five residents per day to ensure orderly transfer of medical records, medications, and personal belongings and funds.

Jefferson Park also provided weekly updates to VDH during the seven weeks of closing.

VDH staff indicated that they received no complaints from Jefferson Park residents or their families during the closure. Staff noted that the complaints they received were from patient advocates and community members concerned that Charlottesville was losing nursing home beds.

Virginia Department of Health Staff Indicated that Current Protections for Nursing Facility Closures Are Adequate

During interviews with JCHC staff, VDH staff indicated that they considered the protections that are already in place regarding voluntary closures to be adequate. These protections include regulatory

requirements and the professional liability that licensed professionals working within nursing facilities assume.

As noted in the previous chapter, federal regulations require certified nursing facilities to provide at least 30 days notice before a resident may be involuntarily transferred or discharged. VDH licensing regulations require advance notice to VDH of at least 30-working days prior to any planned closure. Moreover, the Health Commissioner is granted authority to petition the circuit court to appoint a receiver for a nursing facility that does not provide at least 90 days notice of its intention to close or that has not ensured adequate resident protections.

VDH staff indicated that in addition to these requirements, in practice, there are other inherent protections within the system. Many of the nursing facility staff are licensed health care professionals. Abrupt abandonment of facility residents could place the professional licenses of the administrator and all registered and licensed practical nurses working in the facility in jeopardy. Nursing facilities could also face criminal liability, abuse, and neglect charges if facility residents were abandoned.

Virginia Department of Health Staff Indicated Concerns about Provisions Contained within HB 1920 and SB 845

VDH staff considered the bill provisions related to a 60-day notice and the idea of appointing a receiver to be particularly problematic. VDH staff noted that they would not favor more than a 30-day notice requirement. Facilities that voluntarily close are often having financial difficulties. Under conditions of financial stress, the protections that are in place can only be expected to sustain the facility in a safe manner for a relatively limited period of time. Federal Medicare and Medicaid regulations require a 30-day notice and allow facilities that are in danger of losing their federal certification an additional 30-day payment to provide time for facility improvement or resident relocation. VDH staff noted concerns about how long, beyond the required 30 days, it would be reasonable to expect a facility to staff the facility properly and to purchase the food and supplies needed by the residents.

Similarly, the appointment of a receiver generally assumes that the nursing facility or its parent company will have the financial resources available to support continued operation. A facility or parent company that has declared bankruptcy or has very limited financial assets may not

have financial resources that a circuit court could require to be used in continuing to operate the facility. This could mean that the Commonwealth would have to assume financial and operational responsibility for operating the facility. As noted in the previous chapter, *Code of Virginia* § 32.1-27.1.B already provides authority for the Health Commissioner to petition the circuit court to have a receiver appointed to operate a nursing facility under certain circumstances. Those circumstances include that the nursing facility has given VDH less than 90 days notice of its intention to close or to relinquish its license or provider agreement; that the facility is operating in an unsafe manner, or that the facility has provided VDH with insufficient time to "make adequate and timely arrangements for relocating all patients...[who receive Medicare or Medicaid] to ensure their continued safety and health care." This statutory language would seem to provide adequate authority for the Health Commissioner to address a variety of situations.

VDH staff indicated that staff from the Office of the Attorney General (OAG) have historically recommended against petitioning the court to appoint a receiver. OAG staff interviewed for this study indicated that the prescriptive language contained in HB 1920 and SB 845 is problematic. As noted previously, the proposed substitute for HB 1920 reads that "failure of the licensed...or certified nursing facility to comply with the provisions of this section shall result in the Commissioner petitioning the circuit court...for the appointment of a receiver...." OAG staff stated that permissive language that would allow the appointment of a receiver to be one of a number of possible responses on the part of the state would be preferable. OAG staff stated that because the primary interest of the state is to ensure the health and safety of facility residents, it would be better for the state to have the flexibility to take whatever action would best ensure the health and safety of residents.

The proposed substitute for HB 1920, also indicates that VDH "in consultation with the Departments of Social Services; Medical Assistance Services; Mental Health, Mental Retardation and Substance Abuse Services; the Department for the Aging; and the Office of the State Long-Term Care Ombudsman shall develop and implement a coordinated local level response to ensure the health, safety and welfare of residents...in the event of voluntary or involuntary closure...." These requirements are acceptable to VDH. Moreover, the Department of Medical Assistance Services has developed a formal relocation process to be used when

nursing facilities are involuntarily closed or de-certified for Medicaid or Medicare payments.

Department of Medical Assistance Services Staff Did Not Observe Problems in the Closing of Jefferson Park Center

DMAS, which provided on-site staff and assistance during the closing of Jefferson Park Center, indicated that its staff were "very involved in the entire process." A DMAS social worker was on-site for three days following the announcement of the closing and for at least one day a week during the remaining six weeks. The social worker indicated that she talked with facility staff; walked around the facility in order to observe facility conditions and to talk with residents and their families; and ensured floors were consolidated as residents moved out. The social worker observed that brochures that discussed guidelines for choosing a facility were available at the front desk and notices discussing the role of the Ombudsman and the Department of Social Services were posted. A licensed practical nurse with DMAS was also on-site for the first three days after the closing was announced and then for one additional visit during the closing. Additional DMAS staff were available by telephone to assist in finding available nursing facility beds and to assist Jefferson Park staff.

DMAS staff noted that additional assistance could have been provided but was not considered to be needed because Jefferson Park Center had a well-developed plan and facility staff seemed to work well with residents concerning the relocations. DMAS staff indicated that they specifically asked residents' families about the relocation process to ensure that they were satisfied with how it was being handled. DMAS staff indicated that they received no complaints from Jefferson Park residents or their families concerning the closing of Jefferson Park Center. This does not mean that no problems were experienced in the closure process but only that DMAS staff were not advised of any problems.

DMAS Staff Indicated Concerns about Provisions Contained within HB 1920 and SB 845

DMAS staff indicated concerns about the bill provision which would require a 60-day notice prior to closing a nursing facility. In interviews with JCHC staff, DMAS stated that it is usually better to try to move residents relatively quickly since profitable facilities are not typically the facilities that close. In a facility that has limited financial resources

available, it is difficult to maintain staffing, keep the utilities on, and pay vendors in cash if necessary to ensure that food and supplies continue to be delivered. DMAS staff also indicated that once some of the residents begin to move out, the other residents typically prefer to move out also.

The Relocation Process Developed by DMAS for Involuntary Closures of Nursing Facilities Could Be Modified to Apply to Voluntary Closures

DMAS assumes the lead role in relocation assistance when nursing facilities are closing. DMAS has access to information about the location of Medicaid-approved beds and has staff who work with the facility in relocating residents. DMAS may be able to access Civil Monetary Penalty (CMP) funding to assist a facility that is being involuntarily closed due to serious non-compliance with federal certification standards. In these instances, this funding may be used to assist residents in relocating and in assisting the facility in maintaining quality of care while it is closing. CMP funds may not be used to assist in relocations or quality of care issues for facilities that are voluntarily closing. However, for residents whose care is paid by Medicaid, there are some Medicaid-transportation funds that can be used to pay for special transportation needs such as ambulance or Medflight requirements even during voluntary closures.

DMAS established a formal relocation process in 1996 for use when nursing facilities are involuntarily closed or de-certified for Medicare or Medicaid payments. DMAS representatives have suggested that the relocation process could be modified for use during voluntary closures to ensure that nursing facility residents are protected. The only modifications that would be needed would be the omission of requirements that are specific to termination of the facility's Medicare and/or Medicaid provider agreement. For example, DMAS is required to post a notice in the newspaper at least 15 days before a provider agreement for Medicare or Medicaid is terminated. This requirement would not apply to a facility that is voluntarily closing.

Figure 9 illustrates a relocation process that is based on DMAS' current process for involuntary nursing facility closures but has been modified for illustrative purposes to address voluntary closures. As Figure 9 shows, the process seeks to involve a number of different state and local resources to assist residents in relocating. DMAS has divided the relocation process into three phases which focus on planning, seeking new living arrangements, and the moving process. The agencies listed under

Figure 9
Relocation Plan for Voluntary Closure of Nursing Facilities Based on DMAS Plan for Involuntary Closures

- DMAS notifies VDH, DSS, VDA, State Ombudsman, and DMHMRSAS (if applicable) of facility's intention to close.
- DMAS and DSS identify leaders for relocation team, identify and organize staff for relocation team, and consult with State Ombudsman. Meeting is held to assign duties among state, regional, and local resources.
- Family meeting is scheduled and held after residents' families have been given advance notice of the meeting. During the meeting, residents and families are apprised of the reason and timeframe for the closing and the assistance and protections that will be provided during the transition.

Phase I: Planning Relocation

Resident assessments made and acuity is determined -- DMAS.

Individual meetings are held with residents to determine their preferences in relocating -- DSS, Ombudsman, DMHMRSAS.

Quality of care and staffing in the facility are monitored and any concerns are reported to the relocation coordinator -- all staff who are on-site.

Available nursing facility beds are identified -- DMAS.

Phase II: Seeking New Living Arrangements

Relocation alternatives are discussed with residents and any preparations such as assessments are initiated -- all staff.

Relocation arrangements are made and local agencies are alerted regarding planned relocations -- all staff.

Quality of care and staffing in the facility are monitored and any concerns are reported to the relocation coordinator -- all staff who are on-site.

Residents who refuse to leave or appear to be incapable of making an informed decision will be reviewed by APS, legal actions such as an emergency protective service order or guardianship petition may be undertaken -- DSS.

Phase III: The Moving Process

Transportation is arranged, belongings are packed, and family notifications are undertaken, as needed -- all staff.

Actual relocation dates are verified with receiving facilities to ensure that all arrangements and services will be ready for the resident -- all staff. Physician transfer orders are secured -- DMAS.

Quality of care and staffing in the facility are monitored and any concerns are reported to the relocation coordinator -- all staff who are on-site.

Following the relocation, family, responsible parties (including local agencies with financial responsibility), and attending physicians are sent approved form letters regarding the resident's new place of residence -- all staff.

Source: JCHC staff analysis of DMAS relocation plan that could be required for involuntary nursing facility closures.

the three phases of relocation are expected to be the agencies that have primary rather than sole responsibility for performing each of the procedures. The primary relocation procedures include identifying available nursing facility beds; determining resident care needs; meeting with residents and their families/responsible parties regarding relocation preferences, and, later, to make relocation arrangements; and to continually monitor quality of care in the facility that is closing.

Department of Social Services Staff Have Concerns Related to Assisted Living Facility Closures that May Be Exacerbated by Certain Provisions of HB 1920 and SB 845

DSS staff indicated that although they were not aware of problems occurring during the closing of the assisted living section of Jefferson Park Center, a number of assisted living closures have been quite problematic. As noted in the previous chapter, approximately 50 assisted living facilities close or change ownership each year. While the majority of these facility changes go well and require little intervention by DSS, approximately three closings a year require extensive intervention by adult protective services staff. APS staff reported encountering significant difficulties because residents may need to be moved quickly to ensure their safety, and because a dedicated source of funding is not available to fund relocation costs. DSS indicated that provisions of HB 1920 and SB 845 generally do not address these problems and in some cases the bill provisions may exacerbate the problems.

Assisted Living Facility Residents Often Need to Be Moved Quickly: Although licensing standards require assisted living facilities to provide residents advance notice of at least 14 days before discharge, a number of facilities have given much less notice before closing. APS staff indicated that they have been given as little as several days notice that a facility was closing. The following is a description of a recent APS case that resulted in the need for DSS to quickly close an assisted living facility:

> APS received a call on March 20th from a worker in an assisted living facility. The facility's owner who was planning to leave on an overseas trip in three days had left without providing for staff to continue to operate the facility in his absence. The worker indicated that she had been the only staff member on duty for many hours. Most of the facility's 16 residents needed to be given their medication but the staff member was not qualified to administer

medication. The worker was threatening to leave if assistance was not forthcoming. APS staff were able to contact the facility owner who arranged for staff to work in the facility for a limited period of time. APS in concert with the local CSB were able to relocate the 16 residents by April 6th allowing the facility to close.

In this case, the provisions of HB 1920 and SB 845 would have required DSS to petition the circuit court to appoint a receiver to operate the facility. It is unlikely that there would have been facility assets that the court could attach presumably meaning that the state would have to assume the cost and responsibility for operating the facility.

DSS licensing staff indicated that the case example cited above is not an isolated incident. It is not unusual for a smaller facility to rely on the owner to be the primary provider of services to residents. If that owner becomes very ill or dies, it is often best to move the residents and close the facility as soon as possible to ensure that quality of care does not suffer. Smaller facilities are not the only ones that close quickly. In June 1997, Kensington Gardens, a large Richmond facility that was having financial and licensing problems, decided to close after giving residents 14 days advance notice. At the time the announcement was made there were 252 residents, 197 of whom received an auxiliary grant supplement. DSS placed a staff member in the facility 24 hours each day to monitor quality of care as the facility closed. DSS was assisted by seven other state and local agencies in helping to relocate all of the residents during the 14 day period that was provided.

There Is No Funding Source for Relocation Costs: There is no dedicated funding source available to DSS and local departments of social services to pay for extraordinary costs related to resident relocations. Examples of relocation costs that APS has assumed include:

- special emergency placement for a mentally ill resident until an appropriate placement could be arranged by the community services board ($2,550 for one month),
- Emergency Orders for Protective Services (ranges from $50 to $150 per court case), and
- testing for tuberculosis ($11 per resident).

These reported costs are in addition to costs incurred when residents are transported in state or city vehicles to visit or move to another facility, and

compensatory time (in those local social services departments that provide for compensatory time for overtime worked). These costs were funded from the APS funds of the local social service departments. APS is not considered to be a fully funded program. Total APS funding in FY 2002 for 121 local departments of social services is $1 million, which is far short of the $5 million that is estimated by DSS to be the cost to fully fund APS at the local level.

The Department of Social Services Has Developed Voluntary Guidelines for Assisting with Resident Relocations from Assisted Living Facilities

Following the closing of a large assisted living facility in Richmond, DSS developed voluntary guidelines that would be useful in resident relocations. DSS indicated that the document, *Assisted Living Facility Resident Relocation: Guidelines for Localities* was developed through the collaboration of a number of different agencies including staff from area agencies on aging, community services boards, a local ombudsman office, a local social services agency, DSS, and DMAS. The guidelines emphasize that while state and local entities are available to provide support, the assisted living facility is expected to assume primary responsibility for relocating residents during a closure.

Figure 10 summarizes the procedures set forth in the resident relocation guidelines for assisted living facilities. The guidelines are similar in focus to the relocation plan that DMAS developed for involuntary closures in terms of assessing resident care needs, identifying available facility beds, assisting residents in relocating, and assuring quality of care during the transition. There are important differences in practice however.

Whereas nursing facilities must be certified by VDH to receive Medicaid payments, the DSS license that assisted living facilities receive has nothing to do with whether the facility accepts auxiliary grant payments. Thus, DMAS has information regarding the availability of beds approved for Medicaid reimbursement, but DSS has no comparable source of information regarding the availability of assisted living facilities that accept auxiliary grant payments. Moreover, while a majority of nursing facility residents receive Medicaid, 80 percent of assisted living residents pay for their own care. Consequently, it is much more difficult to identify unoccupied beds that are available for auxiliary grant recipients than for Medicaid recipients.

Figure 10

Procedures Included in Guidelines Developed for Relocating Residents of Assisted Living Facilities

- DSS Licensing staff notify prospective relocation team members and provide basic information about the facility that is closing including the number of residents and the number of residents receiving the auxiliary grant.
- The relocation team is expected to include representatives from the assisted living facility, DSS Licensing and Adult Services/Adult Protective Services, DMAS, VDA, the state or local Ombudsman Office, a local department of social services, a CSB, and an area agency on aging.
- The relocation team elects a team coordinator (who is typically the regional licensing supervisor) and clarifies team member responsibilities.

On-site Responsibilities	Off-Site Responsibilities
Meet with residents and their families and other responsible parties and collect information on each resident.	Identify available beds including beds within facilities that accept the auxiliary grant.
Implement a notification process if the facility has not already done so -- both verbal and written notification is to be provided.	Notify service providers, resident physicians, and local social services workers as applicable.
Post notice of contacts for relocation questions.	Notify elected and public officials and corporate leaders (depending on the circumstances of the closure).
Hold a resident/family meeting or meetings in a place large enough to accommodate residents and family members (church, school, fire station, etc. if necessary).	Notify Social Security Administration of new addresses for recipients of Supplemental Security Income so checks can be forwarded.
Determine payment status of each resident (private pay or auxiliary grant).	Identify funding sources for any extraordinary expenses that may be incurred -- transportation, medical examinations and vaccinations, etc.
Review resident records, ensure the uniform assessment instrument is up-to-date and accurate.	
Provide listing of facilities with openings.	
Assist with packing and transportation as needed.	

Source: JCHC staff analysis of *Assisted Living Facility Resident Relocation: Guidelines for Localities.*

Another important difference is that state agencies typically provide most of the assistance when a nursing facility closes. When an assisted living facility closes, local entities provide most of the assistance. This means that the assistance provided for assisted living facilities is much

more dependent on the resources and cooperation available from local entities. It is clearly more difficult to require local cooperation (particularly when there is no specific funding provided to assist in facility closures) than to require state agencies to provide assistance.

The Department of Social Services Reported Concerns that Adult Abuse, Neglect, and Exploitation Are Under-Reported Even by Mandated Reporters

While not a specific focus of the study, the issue of the reporting of adult abuse, neglect and exploitation was raised in the course of completing the study. APS staff indicated that under-reporting of adult abuse and neglect is widespread and unaffected by current statutory requirements related to mandated reporters and penalties associated with failure to report. *Code of Virginia* § 63.1-55.3 defines a mandated reporter of suspected abuse, neglect or exploitation as including medical and mental health professionals, social workers, law enforcement agents, and "any person employed by a public or private agency or facility and working with adults...who has reason to suspect that an adult is an abused, neglected or exploited adult shall report the matter immediately to the local department" of social services. Despite this clear mandate to report, APS staff continually learn of instances of unreported abuse, neglect, and exploitation from newspaper articles that quote individuals who are mandated reporters and from surveys and reports completed by state agencies. APS staff indicated that none of the reported instances of abuse and neglect that occurred at Oak Hill were reported.

APS can only be effective in protecting Virginia's vulnerable elderly and disabled if there is reliable reporting and adequate resources provided for needed intervention. JCHC proposed budget amendments of $6 million for APS for each year of the 2000-2002 biennium. Annual funding of $225,000 was approved. The JCHC Long-Term Care Subcommittee heard testimony during public hearings held last summer about the need for additional resources and increased awareness of addressing adult abuse, neglect, and exploitation. In determining this year's workplan for the Long-Term Care Subcommittee, it is likely that the issue of protecting the elderly and disabled will be included.

Industry Associations Indicated Concerns about Provisions of HB 1920 and SB 845

JCHC staff met with representatives of the Virginia Association of Nonprofit Homes for the Aging, the Virginia Health Care Association, and the Virginia Hospital and Healthcare Association to discuss the provisions of HB 1920 and SB 845. Industry representatives agreed on the need for all parties -- the long-term care facility, and state and local entities -- to work together in assisting residents when a facility is closing. A primary concern expressed by industry representatives was any new statutory requirement that could provide new grounds for lawsuits. It was noted that while liability insurance rates are high, long-term care facilities in Virginia are generally able to obtain liability insurance. Industry representatives indicated their concern that including a 60-day notice of closing in statute could result in liability insurance becoming more expensive and more difficult for facilities in Virginia to obtain.

During the 2001 General Assembly Session, JCHC staff were told of problems concerning the expense and availability of liability insurance for long-term care facilities. JCHC staff talked with several insurance brokerages about the situation. A representative of one of the largest insurance brokerages in the nation indicated that there is a nationwide problem with "skyrocketing" increases in the cost of liability insurance for many types of elder care providers from nursing homes to personal care providers. According to the insurance representative, liability insurance is more readily available in Virginia than in some states because a limit of $350,000 has been set for punitive damages. States such as Florida and Texas which have no such limit have been particularly hard hit by liability insurance increases. Another insurance representative contacted by JCHC staff stated that liability insurance rates in all states have increased dramatically in recent months due to large losses that have been sustained throughout the nation in the elder care industry. This has resulted in a marked reduction in the number of companies that are willing to underwrite liability insurance for elder care facilities.

Industry representatives also stated that it would be difficult for many facilities to ensure quality of care for 60 days after announcing plans to close. Representatives stated that facilities would need to have the financial resources to offer severance packages to their staff and to continue to pay for food, supplies, utilities, and facility maintenance to ensure that resident care would not suffer. Industry representatives

believe that only a limited number of facilities would have the financial resources that would be needed to continue to remain open at low capacity for up to 60 days.

Industry representatives did not object to the concept of receivership. As noted previously, the Health Commissioner has the authority to request the appointment of a receiver for a nursing facility if less than 90 days notice of closing is given and under certain other circumstances. Representatives questioned what the legal status of the state would be if a facility did not have financial resources for the circuit court to attach.

Industry representatives expressed support for establishing a relocation process for voluntary closures that is equivalent to the process DMAS established for involuntary closures. Moreover, during the 2001 General Assembly Session, industry associations supported an approach that would have required the Secretary of Health and Human Resources to coordinate the work of various state agencies "to ensure the health, safety, and welfare of residents of nursing homes and assisted living facilities in the event of a voluntary or involuntary closure." This approach was not formally drafted by legislative services for consideration.

Statutory Protections Provided by Other States for Residents of Long-Term Care Facilities

An analysis of the statutory provisions of other states was completed by contract staff of the Jefferson Area Board for Aging in early January 2001. In completing the analysis, other state statutes were specifically reviewed for any provisions related to voluntary closures. Consequently, if another state had requirements related to facility closure in general, those requirements were not identified. The JABA analysis found that Oklahoma, Maine, and Texas statutorily address voluntary closure requirements for nursing facilities; Alaska and Florida statutorily address voluntary closure requirements for assisted living facilities; and Illinois statutorily addresses voluntary closure requirements for both nursing and assisted living facilities. (No study was identified by JCHC or JABA staff regarding requirements that various states have for their long-term care facilities that intend to close voluntarily.)

Figure 11

Other State Statutes Related to Voluntary Closure of Long-Term Care Facilities

Statutory Requirements for Nursing Facilities

State Citation	Notice Requirements	Specified Sanctions
Illinois §§ 210 ILCS 45/3-423 & 504 Nursing Home Care	At least 90 days prior to any voluntary closure must be given to the licensing agency, residents, resident representatives, and if possible to residents' families.	A petition may be filed for a court-appointed receiver if the facility is closing "and adequate arrangements for relocation of residents have not been made at least 30 days prior to closure...."
Maine § 22-1822 Nursing Home	At least 30 days advance notice of any voluntary closure is to be given to patients "and to those persons, governmental units or institutions who are primarily responsible for the welfare of those patients...."	None
Oklahoma § 63-1-1930 Nursing Home Care	At least 90 days notice prior to any voluntary closure is to be given to the licensing agency, residents, resident representatives, and if possible to residents' families. The licensing agency may establish a relocation team within a facility that is closing.	None
Texas § 242.100 Nursing or Convalescent Homes	"[N]ot later than one week after the date on which the decision to [voluntarily] close is made" notice is to be provided to residents and subsequent written notice to "each resident's nearest relative or person responsible for the resident's support...."	None

Statutory Requirements for Assisted Living Facilities

State Citation	Notice Requirements	Specified Sanctions
Alaska § 47.33.080 Assisted Living Homes	At least 90 days prior to the voluntary closure or relocation, written notice must be given to the licensing agency, residents, resident representatives, and service coordinators.	None
Florida § 400.431 Assisted Living Facilities	At least 90 days prior to the voluntary "discontinuation of operation," written notice must be given to the licensing agency, residents or their families, legal representatives, and/or responsible agencies.	Fine of no more than $5,000 on "each person or business entity that owns any interest in a facility that terminates operation without providing notice...at least 30 days before operation ceases."
Illinois § 210 ILCS 9/100 Assisted Living and Shared Housing	At least 90 days prior to any voluntary closure that will require residents to move, notice must be given to the licensing agency, residents, resident representatives, and if possible to residents' families.	None

Source: JCHC staff analysis of state statutes compiled for the Jefferson Area Board for Aging.

Figure 11 summarizes the provisions that were identified in the JABA analysis. As indicated, Illinois, Oklahoma, Maine, and Texas have specific statutory provisions for nursing facilities that voluntarily close. Illinois and Oklahoma require a 90-day notice prior to any voluntary closure that would require more than ten percent of the facility's residents to move. Oklahoma statutes also allow the licensing agency to form a relocation team within the nursing facility that is closing. Maine requires a 30-day notice. Texas requires written notice to be given "not later than one week after the date on which the decision to close is made." Alaska, Florida, and Illinois have statutory provisions that require assisted living facilities to give 90 days prior notice. Two of the six states that JABA identified as statutorily addressing voluntary closure also specified sanctions that could be assessed. Illinois allowed for a court-appointed receiver if a nursing facility failed to make adequate relocation arrangements or failed to give notice at least 30 days prior to closing. Florida allowed for a fine of not more than $5,000 per owner/facility if the assisted living facility failed to provide advance notice at least 30 days prior to closing.

IV.
Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to pursue with regard to protecting the residents of long-term care facilities that decide voluntarily to close.

Option I: **Take no action.**

Option II: **Introduce legislation to amend Titles 32.1 and 63.1 of the *Code of Virginia* to incorporate the provisions of the Amendment in the Nature of a Substitute proposed for House Bill 1920 during the 2001 General Assembly Session. (See language in Appendix C.)**

Option III: **Introduce legislation to amend Titles 32.1 and 63.1 of the *Code of Virginia* to incorporate one or more of the following provisions:**

A. **Require that the Resident Relocation Plan used by the Department of Medical Assistance Services for involuntary nursing facility closures be adapted and used in all voluntary nursing facility closures.**

B. **Require that the Resident Relocation Guidelines developed by the Department of Social Services be followed when an assisted living facility decides to close.**

C. **Include statutory provisions, consistent with federal certification requirements, that require residents to be given at least 30 days notice of a nursing facility's intention to close or to relinquish its license or certification.**

D. **Include statutory provisions that would require the Secretary of Health and Human Resources to coordinate the work of state agencies to "ensure the health, safety, and welfare of residents of nursing facilities and assisted living facilities in the event of a voluntary or involuntary closure of such facility."**

APPENDIX A

SENATE OF VIRGINIA

WARREN E. BARRY
37TH SENATORIAL DISTRICT
PART OF FAIRFAX AND
PRINCE WILLIAM COUNTIES, AND
PART OF THE CITY OF FAIRFAX
POST OFFICE BOX 1146
FAIRFAX, VIRGINIA 22030-1146

COMMITTEE ASSIGNMENTS:
EDUCATION AND HEALTH, CHA
COMMERCE AND LABOR
FINANCE
TRANSPORTATION
RULES

April 4, 2001

The Honorable William T. Bolling, Chairman
Joint Commission on Health Care
1001 East Broad Street
Richmond, Virginia 23219

Dear Senator Bolling:

During the 2001 Session, the Senate Committee on Education and Health considered SB 845 (Couric), relating to protection for residents and consumers in the event of voluntary closure or nonrenewal of licensure or nonrenewal of a Medicaid provider agreement by a nursing home or assisted living facility. Upon the recommendation of the Health Care Subcommittee, the Senate Committee on Education and Health approved a motion to leave this bill in committee, based on concerns about possible unintended effects on the quality of care due to financial difficulties within the facilities. Thus, the Committee approved a motion to table the bill and to refer its issues to the Joint Commission on Health Care for consideration by its Long-Term Care Subcommittee.

The Long-Term Care Subcommittee is asked to examine SB 849 in relationship to the many issues it presents, including, but not limited to (i) timely notice to residents, their relatives or other legal representatives of the intent to close a facility or not renew a license or provider agreement; (ii) planning for relocation of the residents vis-a-vis availability of and access to other facilities and needed health services; (iii) adequate notice to and input from other local or regional health care providers concerning the pending relocation of residents; (iv) adequate information on the geographic distribution of relocation facilities and the travel and transportation implications for residents, their relatives or other legal representatives; (v) realistic information on the physical condition, accommodations, and services of the proposed relocation facilities and the availability of needed health services near the facilities; (vi) adequate consideration of the personal desires and needs of the residents, their relatives or other legal representatives; and (vii) provision of options and choices for relocation to the residents, their relatives or other legal representatives.

I respectfully request, on behalf of the members of the Senate Committee on Education and Health, that the Joint Commission on Health Care include this matter in its study plan for the 2001 interim and provide the Senate Committee on Education and Health with any recommendations on this matter at its earliest convenience. Thank you in advance for your consideration of this request.

Sincerely,

Senator Warren E. Barry, Chairman
Senate Committee on Education and Health

cc: Members, Senate Committee on Education and Health
The Honorable Emily Couric

Enclosures

APPENDIX B

018858964

HOUSE BILL NO. 1920

Offered January 10, 2001

Prefiled January 8, 2001

A BILL to amend and reenact § 63.1-179.1 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 32.1-131.1 and 63.1-178.2, relating to voluntary closure or nonrenewal of license or provider agreements of long-term care facilities.

Patrons—Van Yahres, Brink, Darner, Harris, Morgan and Watts; Senator: Couric

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That § 63.1-179.1 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding sections numbered 32.1-131.1 and 63.1-178.2 as follows:

§ 32.1-131.1. Voluntary closure or nonrenewal of license or provider agreement of nursing home or certified nursing facility.

A. Whenever a licensed nursing home or certified nursing facility intends to voluntarily close or chooses not to renew its license or Medicare or Medicaid provider agreement, the licensed nursing home or certified nursing facility shall notify in writing the Department, patients residing in the nursing home or certified nursing facility, and their authorized representatives and physicians, of its intent to close or not renew its license or provider agreement no less than 120 days in advance of its intended closure or nonrenewal of license or provider agreement in order to provide patients and their authorized representatives with the time needed to search for and select a new licensed nursing home, certified nursing facility or other facility in which to reside.

B. The licensed nursing home or certified nursing facility shall submit a relocation plan for all patients within seven days of the written notification of intent required in subsection A to the Department for its approval and provide a copy to the Office of the State Long-Term Care Ombudsman. Such relocation plan shall include patient profiles as defined in subsection C. The Department shall not approve the relocation plan until it has received comment from the Office of the State Long-Term Care Ombudsman and local relocation team. Department review and approval of the relocation plan shall occur within seven calendar days of receipt of the Office of the State Long-Term Care Ombudsman and local relocation team's recommendations.

C. Within seven calendar days after the notice of intent required by subsection A is submitted to the Department by the licensed nursing home or certified nursing facility, a local relocation team shall be appointed by the Department. The relocation team shall include representatives from the Department, the Department of Medical Assistance Services, the local long-term care ombudsman, the local department of social services and, when appropriate, the local community services board. The costs of the relocation team shall be absorbed by the agencies named in this subsection as part of their normal duties and responsibilities. The local relocation team shall:

1. Review the patient relocation plan and submit comments to the Department that include, but are not limited to, the plan's ability to address individual patient care needs, within fourteen calendar days after the formation of the local relocation team.

2. Review patient's charts for documentation noting that patient's authorized representatives and physicians have been contacted and notified of intended closure.

3. Make unannounced visits to assure staffing and facility operations, e.g., nursing services, meals, laundry, are appropriate for number and level of acuity of current patients in the facility.

4. Review patient charts as necessary to monitor quality of care.

5. Talk with patients and their authorized representatives about exercising their choice in the selection of a new nursing home or facility with regard to its licensing status and survey results, as well as other consumer information, including home and community-based services options.

6. Review relocation arrangements and assure that a patient profile has been completed for each patient and that patient relocation occurs in an organized manner.

The relocation team shall conduct subdivisions 2 through 6 as appropriate throughout the period from formation of the team until closure of the nursing home or facility.

For purposes of this section, a "patient profile" means a document that includes a patient's likes and dislikes regarding such things as living conditions and activities, pertinent information about the patient's medical care and physical condition, staff care strategies and other information unique to that patient.

D. The licensed nursing home or certified nursing facility shall not relocate any patients until the Department has provided written approval of its relocation plan. No patient shall be relocated unless his care needs have been reassessed since the notification of closure occurred.

E. Failure of the licensed nursing home or certified nursing facility to comply with the provisions of this section shall result in the Commissioner petitioning the circuit court for the jurisdiction in which the nursing home or certified nursing facility is located for the appointment of a receiver in accordance with the provisions of subsection B of § 32.1-27.1.

§ 63.1-179.1. Enforcement and sanctions.

A. The Board shall promulgate regulations for the Commissioner to use in determining when the imposition of administrative sanctions or initiation of court proceedings, severally or jointly, is appropriate in order to ensure prompt correction of violations involving noncompliance with state law or regulation as discovered through any inspection or investigation conducted by the Departments of Social Services, Health, or Mental Health, Mental Retardation and Substance Abuse Services. *Such sanctions or actions may include (i) reducing the licensed capacity of any assisted living facility, (ii) restricting or prohibiting new admissions to any assisted living facility, (iii) petitioning the court to impose a civil penalty against any assisted living facility, and (iv) petitioning the court to appoint a receiver for the assisted living facility pursuant to subsection B.* Notwithstanding any other provision of law, following a proceeding as provided in § 9-6.14:11, the Commissioner may issue a special order for violation of any of the provisions of this article, § 54.1-3408, or any rule or regulation promulgated under any provision of this article which adversely impacts, or is an imminent and substantial threat to, the health, safety or welfare of the person cared for therein, or for permitting, aiding, or abetting the commission of any illegal act in an assisted living facility. The issuance of a special order shall be considered a case decision as defined in § 9-6.14:4. The Commissioner shall not delegate his authority to impose civil penalties in conjunction with the issuance of special orders. The Commissioner shall also have the power to revoke or deny the renewal of the license for any assisted living facility for violation of any of the provisions of this article, § 54.1-3408, or any rule or regulation promulgated under any provision of this article which adversely impacts, or is an imminent and substantial threat to, the health, safety or welfare of the person cared for therein, or for permitting, aiding, or abetting the commission of any illegal act in an assisted living facility.

B. The Commissioner may petition the circuit court for the jurisdiction in which any assisted living facility is located for the appointment of a receiver whenever such assisted living facility shall (i) receive official notice from the Commissioner that its license has been or will be revoked; or (ii) advise the Department of its intention to close or not to renew its license less than ninety days in advance; or (iii) operate at any time under conditions that present a major and continuing threat to the health, safety, security, rights or welfare of the residents, including the threat of imminent abandonment by the owner or operator, or a pattern of failure to meet ongoing financial obligations such as the inability to pay for essential food, pharmaceuticals, personnel, or required insurance; and (iv) the Department is unable to make adequate and timely arrangements for relocating all patients in order to ensure their continued safety and health care.

Upon filing of a petition for appointment of a receiver, the court shall hold a hearing within ten days, at which time the Department and the owner or operator of the assisted living facility may participate and present evidence. The court may grant the petition if it finds any one of the conditions identified in (i) through (iii) above to exist in combination with the condition identified in (iv) and the court further finds that such conditions will not be remedied and that the patients will not be protected unless the petition is granted.

No receiver established under this subsection shall continue in effect for more than 180 days without further order of the court.

The appointed receiver shall be a person meeting the qualifications for administrator of an assisted living facility pursuant to regulations promulgated by the Board or, if not so qualified, shall employ and supervise a person so qualified to administer the day-to-day business of the assisted

living facility.

The receiver shall have (i) such powers and duties to manage the assisted living facility as the court may grant and direct, including but not limited to the duty to accomplish the orderly relocation of all patients and the right to refuse to admit new residents during the receivership; (ii) the power to receive, conserve, protect and disburse funds, including Medicare and Medicaid payments on behalf of the owner or operator of the assisted living facility; (iii) the power to execute and avoid executory contracts; (iv) the power to hire and discharge employees; and (v) the power to perform all other acts, including the filing of such reports as the court may direct, subject to accounting to the court therefor and otherwise consistent with state and federal law, necessary to protect the patients from the threat or threats set forth in the original petitions, as well as such other threats arising thereafter or out of the same conditions.

The court may grant injunctive relief as it deems appropriate to the Department or to its receiver either in conjunction with or subsequent to the granting of a petition for appointment of a receiver under this section.

The court may terminate the receivership on the motion of the Department, the receiver, or the owner or operator, upon finding, after a hearing, that either (i) the conditions described in the petition have been substantially eliminated or remedied, or (ii) all residents in the assisted living facility have been relocated. Within thirty days after such termination, the receiver shall file a complete report of his activities with the court, including an accounting for all property of which he has taken possession and all funds collected.

All costs of administration of a receivership hereunder shall be paid by the receiver out of reimbursement to the assisted living facility from Medicare, Medicaid and other resident care collections. The court, after terminating such receivership, shall enter appropriate orders to ensure such payments upon its approval of the receiver's reports.

A receiver appointed under this section shall be an officer of the court, shall not be liable for conditions at the assisted living facility that existed or originated prior to his appointment and shall not be personally liable, except for his own gross negligence and intentional acts that result in injuries to persons or damage to property at the assisted living facility during his receivership.

The provisions of this subsection shall not be construed to relieve any owner, operator or other party of any duty imposed by law or any civil or criminal liability incurred by reason of any act or omission of such owner, operator, or other party.

§ 63.1-178.2. Voluntary closure or nonrenewal of license of assisted living facility.

A. Whenever a licensed assisted living facility intends to voluntarily close or chooses not to renew its license, the assisted living facility shall notify in writing the Department, residents of the assisted living facility, and their authorized representatives and physicians, of its intent to close or not renew its license no less than 120 days in advance of its intended closure or nonrenewal of license in order to provide residents and their authorized representatives with the time needed to search for and select a new assisted living facility or other facility in which to reside.

B. The licensed assisted living facility shall submit a relocation plan for all residents within seven days of the written notification of intent required in subsection A to the Department for its approval and provide a copy to the Office of the State Long-Term Care Ombudsman. Such relocation plan shall include resident profiles as defined in subsection C. The Department shall not approve the relocation plan until it has received comment from the Office of the State Long-Term Care Ombudsman and local relocation team. Department review and approval of the relocation plan shall occur within seven calendar days of receipt of the Office of the State Long-Term Care Ombudsman and local relocation team's recommendations.

C. Within seven calendar days after the notice of intent required by subsection A is submitted to the Department by the assisted living facility, a local relocation team shall be appointed by the Department. The relocation team shall include representatives from the Department, the Department of Medical Assistance Services, the local long-term care ombudsman, the local department of social services and, when appropriate, the local community services board. The costs of the relocation team shall be absorbed by the agencies named in this subsection as part of their normal duties and responsibilities. The local relocation team shall:

1. Review the resident relocation plan and submit comments to the Department that include, but

are not limited to, the plan's ability to address individual resident care needs, within fourteen calendar days after the formation of the local relocation team.

2. Review resident's charts for documentation noting that resident's authorized representatives and physicians have been contacted and notified of intended closure.

3. Make unannounced visits to assure staffing and facility operations, e.g., assisted living care services, meals, laundry, are appropriate for number and level of acuity of current residents in the facility.

4. Review resident files as necessary to monitor quality of care.

5. Talk with residents and their authorized representatives about exercising their choice in the selection of a new assisted living or other facility with regard to its licensing status and survey results, as well as other consumer information, including home and community-based services options.

6. Review relocation arrangements and assure that a resident profile has been completed for each resident and that resident relocation occurs in an organized manner.

The relocation team shall conduct subdivisions 2 through 6 as appropriate throughout the period from formation of the team until closure of the assisted living facility.

For purposes of this section, a "resident profile" means a document that includes a resident's likes and dislikes regarding such things as living conditions and activities, pertinent information about the resident's medical care and physical condition, staff care strategies and other information unique to that resident.

D. The licensed assisted living facility shall not relocate any residents until the Department has provided written approval of its relocation plan. No resident shall be relocated unless his care needs have been reassessed since the notification of closure occurred.

E. Failure of the licensed assisted living facility to comply with the provisions of this section shall result in the Commissioner petitioning the circuit court for the jurisdiction in which the assisted living facility is located for the appointment of a receiver in accordance with the provisions of § 63.1-179.1.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate

015206416

SENATE BILL NO. 845

Offered January 10, 2001

Prefiled December 20, 2000

A BILL to amend and reenact § 63.1-179.1 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 32.1-131.1 and 63.1-178.2, relating to voluntary closure or nonrenewal of license or provider agreements of long-term care facilities.

Patrons—Couric; Delegate: Van Yahres

Referred to Committee on Rehabilitation and Social Services

Be it enacted by the General Assembly of Virginia:

1. That § 63.1-179.1 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding sections numbered 32.1-131.1 and 63.1-178.2 as follows:

§ 32.1-131.1. Voluntary closure or nonrenewal of license or provider agreement of nursing home or certified nursing facility.

A. Whenever a licensed nursing home or certified nursing facility intends to voluntarily close or chooses not to renew its license or Medicare or Medicaid provider agreement, the licensed nursing home or certified nursing facility shall notify in writing the Department, patients residing in the nursing home or certified nursing facility, and their authorized representatives and physicians, of its intent to close or not renew its license or provider agreement no less than 120 days in advance of its intended closure or nonrenewal of license or provider agreement in order to provide patients and their authorized representatives with the time needed to search for and select a new licensed nursing home, certified nursing facility or other facility in which to reside.

B. The licensed nursing home or certified nursing facility shall submit a relocation plan for all patients within seven days of the written notification of intent required in subsection A to the Department for its approval and provide a copy to the Office of the State Long-Term Care Ombudsman. Such relocation plan shall include patient profiles as defined in subsection C. The Department shall not approve the relocation plan until it has received comment from the Office of the State Long-Term Care Ombudsman and local relocation team. Department review and approval of the relocation plan shall occur within seven calendar days of receipt of the Office of the State Long-Term Care Ombudsman and local relocation team's recommendations.

C. Within seven calendar days after the notice of intent required by subsection A is submitted to the Department by the licensed nursing home or certified nursing facility, a local relocation team shall be appointed by the Department. The relocation team shall include representatives from the Department, the Department of Medical Assistance Services, the local long-term care ombudsman, the local department of social services and, when appropriate, the local community services board. The costs of the relocation team shall be absorbed by the agencies named in this subsection as part of their normal duties and responsibilities. The local relocation team shall:

1. Review the patient relocation plan and submit comments to the Department that include, but are not limited to, the plan's ability to address individual patient care needs, within fourteen calendar days after the formation of the local relocation team.

2. Review patient's charts for documentation noting that patient's authorized representatives and physicians have been contacted and notified of intended closure.

3. Make unannounced visits to assure staffing and facility operations, e.g., nursing services, meals, laundry, are appropriate for number and level of acuity of current patients in the facility.

4. Review patient charts as necessary to monitor quality of care.

5. Talk with patients and their authorized representatives about exercising their choice in the selection of a new nursing home or facility with regard to its licensing status and survey results, as well as other consumer information, including home and community-based services options.

6. Review relocation arrangements and assure that a patient profile has been completed for each patient and that patient relocation occurs in an organized manner.

The relocation team shall conduct subdivisions 2 through 6 as appropriate throughout the period from formation of the team until closure of the nursing home or facility.

For purposes of this section, a "patient profile" means a document that includes a patient's likes and dislikes regarding such things as living conditions and activities, pertinent information about the patient's medical care and physical condition, staff care strategies and other information unique to that patient.

D. The licensed nursing home or certified nursing facility shall not relocate any patients until the Department has provided written approval of its relocation plan. No patient shall be relocated unless his care needs have been reassessed since the notification of closure occurred.

E. Failure of the licensed nursing home or certified nursing facility to comply with the provisions of this section shall result in the Commissioner petitioning the circuit court for the jurisdiction in which the nursing home or certified nursing facility is located for the appointment of a receiver in accordance with the provisions of subsection B of § 32.1-27.1.

§ 63.1-179.1. Enforcement and sanctions.

A. The Board shall promulgate regulations for the Commissioner to use in determining when the imposition of administrative sanctions or initiation of court proceedings, severally or jointly, is appropriate in order to ensure prompt correction of violations involving noncompliance with state law or regulation as discovered through any inspection or investigation conducted by the Departments of Social Services, Health, or Mental Health, Mental Retardation and Substance Abuse Services. *Such sanctions or actions may include (i) reducing the licensed capacity of any assisted living facility, (ii) restricting or prohibiting new admissions to any assisted living facility, (iii) petitioning the court to impose a civil penalty against any assisted living facility, and (iv) petitioning the court to appoint a receiver for the assisted living facility pursuant to subsection B.* Notwithstanding any other provision of law, following a proceeding as provided in § 9-6.14:11, the Commissioner may issue a special order for violation of any of the provisions of this article, § 54.1-3408, or any rule or regulation promulgated under any provision of this article which adversely impacts, or is an imminent and substantial threat to, the health, safety or welfare of the person cared for therein, or for permitting, aiding, or abetting the commission of any illegal act in an assisted living facility. The issuance of a special order shall be considered a case decision as defined in § 9-6.14:4. The Commissioner shall not delegate his authority to impose civil penalties in conjunction with the issuance of special orders. The Commissioner shall also have the power to revoke or deny the renewal of the license for any assisted living facility for violation of any of the provisions of this article, § 54.1-3408, or any rule or regulation promulgated under any provision of this article which adversely impacts, or is an imminent and substantial threat to, the health, safety or welfare of the person cared for therein, or for permitting, aiding, or abetting the commission of any illegal act in an assisted living facility.

B. The Commissioner may petition the circuit court for the jurisdiction in which any assisted living facility is located for the appointment of a receiver whenever such assisted living facility shall (i) receive official notice from the Commissioner that its license has been or will be revoked; or (ii) advise the Department of its intention to close or not to renew its license less than ninety days in advance; or (iii) operate at any time under conditions that present a major and continuing threat to the health, safety, security, rights or welfare of the residents, including the threat of imminent abandonment by the owner or operator, or a pattern of failure to meet ongoing financial obligations such as the inability to pay for essential food, pharmaceuticals, personnel, or required insurance; and (iv) the Department is unable to make adequate and timely arrangements for relocating all patients in order to ensure their continued safety and health care.

Upon filing of a petition for appointment of a receiver, the court shall hold a hearing within ten days, at which time the Department and the owner or operator of the assisted living facility may participate and present evidence. The court may grant the petition if it finds any one of the conditions identified in (i) through (iii) above to exist in combination with the condition identified in (iv) and the court further finds that such conditions will not be remedied and that the patients will not be protected unless the petition is granted.

No receiver established under this subsection shall continue in effect for more than 180 days without further order of the court.

The appointed receiver shall be a person meeting the qualifications for administrator of an assisted living facility pursuant to regulations promulgated by the Board or, if not so qualified, shall employ and supervise a person so qualified to administer the day-to-day business of the assisted

living facility.

The receiver shall have (i) such powers and duties to manage the assisted living facility as the court may grant and direct, including but not limited to the duty to accomplish the orderly relocation of all patients and the right to refuse to admit new residents during the receivership; (ii) the power to receive, conserve, protect and disburse funds, including Medicare and Medicaid payments on behalf of the owner or operator of the assisted living facility; (iii) the power to execute and avoid executory contracts; (iv) the power to hire and discharge employees; and (v) the power to perform all other acts, including the filing of such reports as the court may direct, subject to accounting to the court therefor and otherwise consistent with state and federal law, necessary to protect the patients from the threat or threats set forth in the original petitions, as well as such other threats arising thereafter or out of the same conditions.

The court may grant injunctive relief as it deems appropriate to the Department or to its receiver either in conjunction with or subsequent to the granting of a petition for appointment of a receiver under this section.

The court may terminate the receivership on the motion of the Department, the receiver, or the owner or operator, upon finding, after a hearing, that either (i) the conditions described in the petition have been substantially eliminated or remedied, or (ii) all residents in the assisted living facility have been relocated. Within thirty days after such termination, the receiver shall file a complete report of his activities with the court, including an accounting for all property of which he has taken possession and all funds collected.

All costs of administration of a receivership hereunder shall be paid by the receiver out of reimbursement to the assisted living facility from Medicare, Medicaid and other resident care collections. The court, after terminating such receivership, shall enter appropriate orders to ensure such payments upon its approval of the receiver's reports.

A receiver appointed under this section shall be an officer of the court, shall not be liable for conditions at the assisted living facility that existed or originated prior to his appointment and shall not be personally liable, except for his own gross negligence and intentional acts that result in injuries to persons or damage to property at the assisted living facility during his receivership.

The provisions of this subsection shall not be construed to relieve any owner, operator or other party of any duty imposed by law or any civil or criminal liability incurred by reason of any act or omission of such owner, operator, or other party.

§ 63.1-178.2. Voluntary closure or nonrenewal of license of assisted living facility.

A. Whenever a licensed assisted living facility intends to voluntarily close or chooses not to renew its license, the assisted living facility shall notify in writing the Department, residents of the assisted living facility, and their authorized representatives and physicians, of its intent to close or not renew its license no less than 120 days in advance of its intended closure or nonrenewal of license in order to provide residents and their authorized representatives with the time needed to search for and select a new assisted living facility or other facility in which to reside.

B. The licensed assisted living facility shall submit a relocation plan for all residents within seven days of the written notification of intent required in subsection A to the Department for its approval and provide a copy to the Office of the State Long-Term Care Ombudsman. Such relocation plan shall include resident profiles as defined in subsection C. The Department shall not approve the relocation plan until it has received comment from the Office of the State Long-Term Care Ombudsman and local relocation team. Department review and approval of the relocation plan shall occur within seven calendar days of receipt of the Office of the State Long-Term Care Ombudsman and local relocation team's recommendations.

C. Within seven calendar days after the notice of intent required by subsection A is submitted to the Department by the assisted living facility, a local relocation team shall be appointed by the Department. The relocation team shall include representatives from the Department, the Department of Medical Assistance Services, the local long-term care ombudsman, the local department of social services and, when appropriate, the local community services board. The costs of the relocation team shall be absorbed by the agencies named in this subsection as part of their normal duties and responsibilities. The local relocation team shall:

1. Review the resident relocation plan and submit comments to the Department that include, but

APPENDIX C

B. The Department, in consultation with the Departments of Social Services; Medical Assistance Services; Mental Health, Mental Retardation and Substance Abuse Services; the Department for the Aging; and the Office of the State Long-Term Care Ombudsman shall develop and implement a coordinated local level response to ensure the health, safety and welfare of residents of nursing homes or certified nursing facilities in the event of voluntary or involuntary closure of any such facility.

C. Failure of the licensed nursing home or certified nursing facility to comply with the provisions of this section shall result in the Commissioner petitioning the circuit court for the jurisdiction in which the nursing home or certified nursing facility is located for the appointment of a receiver in accordance with the provisions of subsection B of § 32.1-27.1.

§ 63.1-178.2. Voluntary closure or nonrenewal of license of assisted living facility.

A. Whenever a licensed assisted living facility intends to voluntarily close or chooses not to renew its license, the assisted living facility shall notify in writing the Department, residents of the assisted living facility, and their authorized representatives and physicians, of its intent to close or not renew its license no less than sixty days in advance of its intended closure or nonrenewal of license in order to provide residents and their authorized representatives with the time needed to search for and select a new assisted living facility or other facility in which to reside.

B. The Department, in consultation with the Departments of Health; Medical Assistance Services; Mental Health, Mental Retardation and Substance Abuse Services; the Department for the Aging; and the Office of the State Long-Term Care Ombudsman shall develop and implement a coordinated local level response to ensure the health, safety and welfare of residents of assisted living facilities in the event of voluntary or involuntary closure of any such facility.

C. Failure of the licensed assisted living facility to comply with the provisions of this section shall result in the Commissioner petitioning the circuit court for the jurisdiction in which

the assisted living facility is located for the appointment of a receiver in accordance with the provisions of § 63.1-179.1.

§ 63.1-179.1. Enforcement and sanctions.

A. The Board shall promulgate regulations for the Commissioner to use in determining when the imposition of administrative sanctions or initiation of court proceedings, severally or jointly, is appropriate in order to ensure prompt correction of violations involving noncompliance with state law or regulation as discovered through any inspection or investigation conducted by the Departments of Social Services, Health, or Mental Health, Mental Retardation and Substance Abuse Services. Such sanctions or actions may include (i) reducing the licensed capacity of any assisted living facility, (ii) restricting or prohibiting new admissions to any assisted living facility, (iii) imposing a civil penalty against any assisted living facility, and (iv) petitioning the court to appoint a receiver for the assisted living facility pursuant to subsection B.

Notwithstanding any other provision of law, following a proceeding as provided in § 9-6.14:11, the Commissioner may issue a special order for violation of any of the provisions of this article, § 54.1-3408, or any rule or regulation promulgated under any provision of this article which adversely impacts, or is an imminent and substantial threat to, the health, safety or welfare of the person cared for therein, or for permitting, aiding, or abetting the commission of any illegal act in an assisted living facility. The issuance of a special order shall be considered a case decision as defined in § 9-6.14:4. The Commissioner shall not delegate his authority to impose civil penalties in conjunction with the issuance of special orders. The Commissioner shall also have the power to revoke or deny the renewal of the license for any assisted living facility for violation of any of the provisions of this article, § 54.1-3408, or any rule or regulation promulgated under any provision of this article which adversely impacts, or is an imminent and substantial threat to, the health, safety or welfare of the person cared for therein, or for permitting, aiding, or abetting the commission of any illegal act in an assisted living facility.

B. The Commissioner may petition the circuit court for the jurisdiction in which any assisted living facility is located for the appointment of a receiver whenever such assisted living facility shall (i) advise the Department of its intention to close or not to renew its license or its Medicaid provider agreement less than ninety days in advance; or (ii) receive official notice from the Commissioner that its license or its Medicaid provider agreement has been or will be revoked; or (iii) operate at any time under conditions that present a major and continuing threat to the health, safety, security, rights or welfare of the residents, including the threat of imminent abandonment by the owner or operator, or a pattern of failure to meet ongoing financial obligations such as the inability to pay for essential food, pharmaceuticals, personnel, or required insurance; and (iv) the Department is unable to make adequate and timely arrangements for relocating all residents in order to ensure their continued safety and health care.

Upon filing of a petition for appointment of a receiver, the court shall hold a hearing within ten days, at which time the Department and the owner or operator of the assisted living facility may participate and present evidence. The court may grant the petition if it finds any one of the conditions identified in clauses (i) through (iii) above to exist in combination with the condition identified in clause (iv) and the court further finds that such conditions will not be remedied and that the residents will not be protected unless the petition is granted.

No receiver established under this subsection shall continue in effect for more than 180 days without further order of the court.

The appointed receiver shall be a person meeting the qualifications for administrator of an assisted living facility pursuant to regulations promulgated by the Board or, if not so qualified, shall employ and supervise a person so qualified to administer the day-to-day business of the assisted living facility.

The receiver shall have (a) such powers and duties to manage the assisted living facility as the court may grant and direct, including but not limited to the duty to accomplish the orderly relocation of all residents and the right to refuse to admit new residents during the

receivership; (b) the power to receive, conserve, protect and disburse funds, including Medicare and Medicaid payments on behalf of the owner or operator of the assisted living facility; (c) the power to execute and avoid executory contracts; (d) the power to hire and discharge employees; and (e) the power to perform all other acts, including the filing of such reports as the court may direct, subject to accounting to the court therefor and otherwise consistent with state and federal law, necessary to protect the residents from the threat or threats set forth in the original petitions, as well as such other threats arising thereafter or out of the same conditions.

The court may grant injunctive relief as it deems appropriate to the Department or to its receiver either in conjunction with or subsequent to the granting of a petition for appointment of a receiver under this section.

The court may terminate the receivership on the motion of the Department, the receiver, or the owner or operator, upon finding, after a hearing, that either (1) the conditions described in the petition have been substantially eliminated or remedied or (2) all residents in the assisted living facility have been relocated. Within thirty days after such termination, the receiver shall file a complete report of his activities with the court, including an accounting for all property of which he has taken possession and all funds collected.

All costs of administration of a receivership hereunder shall be paid by the receiver out of reimbursement to the assisted living facility from Medicare, Medicaid and other resident care collections. The court, after terminating such receivership, shall enter appropriate orders to ensure such payments upon its approval of the receiver's reports.

A receiver appointed under this section shall be an officer of the court, shall not be liable for conditions at the assisted living facility that existed or originated prior to his appointment and shall not be personally liable, except for his own gross negligence and intentional acts that result in injuries to persons or damage to property at the assisted living facility during his receivership.

The provisions of this subsection shall not be construed to relieve any owner, operator or other party of any duty imposed by law or any civil or criminal liability incurred by reason of any act or omission of such owner, operator, or other party.

2. That the provisions of this act shall become effective on January 1, 2002.

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APPENDIX D

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:
Voluntary Closure Study
SB 845/HB 1920

Individuals/Organizations Submitting Comments

A total of 14 individuals and organizations submitted comments in response to the Voluntary Closure Report.

- AARP
- Alzheimer's Association of the National Capital Area
- Joy Duke
- Jefferson Area Board for Aging
- Mary E. Myers
- National Multiple Sclerosis Society Virginia Consumer Action Network
- Northern Virginia Aging Network
- TLC 4 Long Term Care
- Virginia Association of Area Agencies on Aging
- Virginia Association of Nonprofit Homes for the Aging
- Virginia Center for Assisted Living
- Virginia Health Care Association
- Virginia Hospital & Healthcare Association
- Virginia Long-Term Care Ombudsman Program

Policy Options Included in the Voluntary Closure Study

Option I: Take no action.

Option II: Introduce legislation to amend Titles 32.1 and 63.1 of the *Code of Virginia* to incorporate the provisions of the Amendment in the Nature of a Substitute proposed for House Bill 1920 during the 2001 General Assembly Session. (See language in Appendix C.)

Option III: Introduce legislation to amend Titles 32.1 and 63.1 of the *Code of Virginia* to incorporate one or more of the following provisions:

A. Require that the Resident Relocation Plan used by the Department of Medical Assistance Services for involuntary nursing facility closures be adapted and used in all voluntary nursing facility closures.

B. Require that the Resident Relocation Guidelines developed by the Department of Social Services be followed when an assisted living facility decides to close.

C. Include statutory provisions, consistent with federal certification requirements, that require residents to be given at least 30 days notice of a nursing facility's intention to close or to relinquish its license or certification.

D. Include statutory provisions that would require the Secretary of Health and Human Resources to coordinate the work of state agencies to "ensure the health, safety, and welfare of residents of nursing facilities and assisted living facilities in the event of a voluntary or involuntary closure of such facility."

Overall Summary of Comments

The following table summarizes the comments that were received on each Policy Option. As shown, Options III-A and III-B were supported by the largest number of commenters (six) followed by four favorable comments for Options II and III-C, three for Option I, and two for Option III-D. Option II was specifically opposed by two commenters, while Options III-A through III-D received one comment in opposition.

It should be noted that four associations (Alzheimer's Association of the National Capital Area, Jefferson Area Board for Aging, Northern Virginia Aging Network, and Virginia Association of Area Agencies on Aging) reserve their final comments until a formal interpretation of the *Code of Federal Regulations* Title 42; Chapter IV, Sec. 483.12 is received from the Centers for Medicare and Medicaid Services (formerly known as Health Care Financing Administration).

Policy Option	Number of Comments in Support	Number of Comments in Opposition
I	3	--
II	4	2
III-A	6	1
III-B	6	1
III-C	4	1
III-D	2	1

Summary of Individual Comments

AARP

Jack R. Hundley, Chair, Virginia State Legislative Committee of AARP commented in support of Options III-A through III-D. Mr. Hundley stated, "It certainly is necessary that the several state agencies and local agencies must cooperate for the effective moving of residents when a closing occurs. Residents and their families concerns as to location, mode of movement, quality of care in the new location, cost, etc. must be of paramount consideration. AARP would support Option III; paragraph A, B, C, & D. It would suggest Option III C also include 30 days notice in a voluntary closing for assisted living facilities."

Alzheimer's Association of the National Capital Area

Ian Kremer, Esq. Director of Public Policy commented that "the Alzheimer's Association concurs with the comments...from Erica Wood on behalf of the Northern Virginia Aging Network" (which supported Options II, III-A, and III-B).

Joy Duke

Joy Duke did not support any of the proposed Options but commented regarding the discussion of adult protective services (APS). Ms. Duke noted the following:

"While older adults are not children and we in APS are forever vigilant not to infantilize adults, vulnerable adults do share with young children the inability to call out on their own behalf for help when they are victimized. In recognition of this, Virginia is one of forty-four states with mandatory reporting statutes....The failure of mandated reporters to comply with the law is widely recognized as a problem in Virginia and in the nation. In 1996 the National Center on Elder Abuse conducted the only national elder abuse incidence study ever conducted....The document...report[ed] that for every reported incidence of elder abuse or neglect approximately five go unreported. The incident study looked only at elder abuse in community settings. National estimates of non-reporting are even greater when long-term care facilities are included in the sample. Failure of mandated reporters in Virginia to report is legendary. Area agencies on aging across the state consistently file a combined 3% of all reports;

assisted living facilities staff filed 2% of all reports last fiscal year; and health departments filed 1% of all reports. All employees of these agencies and facilities are mandated reporters....In spite of blatant failure of mandated reporters to report, there has been no prosecution in the Commonwealth for failure to report as provided under the *Code of Virginia* §63.1-55.3....Absent prosecution for failure to report, new *Code* to address the failure of mandated reporters to report would probably not be helpful."

"It would be helpful to increase APS staff at the Department of Social Services central office. When APS was mandated by the 1983 session of the General Assembly a position was created to administer the program....Eighteen years later and a 250% increase in investigations one staff person continues to have overall responsibility for program administration....I ask that the Joint Commission on Health Care consider recommending a second full-time position for administering the APS program in Virginia."

"This is to bring to your attention a second issue related to the APS *Code*....During the 18 years that APS has been a mandated program I have never known any local department of social services who has investigated an APS report and found that a person needs protective services and then fail to provide essential protection because of a lack of funds. The words [in the *Code*] 'to the extent that federal or state matching funds are made available' make for a weaker mandate and suggest something short of a commitment on the part of the Commonwealth to assure protection of adults who are least able to protect themselves. Please consider recommending the removal of this phrase from § 63.1-55.1."

Jefferson Area Board for Aging

Gordon Walker, Chief Executive Officer, Jefferson Area Board for Aging (JABA) indicated, "While JABA cannot endorse any of the options recommended in the Long-Term Care Facilities Study until there is a clearer interpretation of existing federal regulations, we do, however, oppose Option III-D."

In commenting on the study in general, Mr. Walker indicated: "we are very concerned about the study's interpretation of federal regulations related to admission, transfer, and discharge rights. We concur that the Code of Federal Regulations (CFR) Title 42; Chapter IV, Sec. 483.12 requires nursing facilities to give residents at least 30 days notice prior to

transfer or discharge. However, JABA believes this same regulation additionally requires that transfer and discharge notices be individualized for each resident, and that they must contain: the reason for transfer; the effective date of transfer; the location to which the resident is transferred; and a statement that the resident has the right to appeal the action to the State. Jefferson Park Center (JPC) did not give detailed notice as required by federal regulation. If JPC had been compelled to comply with this regulation the facility could not have closed until 70 or 72 days after the closure was announced." Mr. Walker indicated that JABA believes that in addition to the federal regulations cited previously, JPC violated "Title II of the Americans with Disabilities Act of 1990 as interpreted by the Olmstead...decision by failing to evaluate residents who wished to be transferred to less restrictive community settings."

Mr. Walker specifically requested "that the Joint Commission on Health Care seek a formal interpretation of...[*Code of Federal Regulations* Title 42; Chapter IV, Sec. 483.12] as soon as possible from the Centers for Medicare and Medicaid Services...."

Mary E. Myers

Mary E. Myers commented in support of Option II. Ms. Myers indicated, "I have a Mom and friends at nursing homes and of course, am very concerned about any nursing home issues."

National Multiple Sclerosis Society Virginia Consumer Action Network

Christine Cannaday commented on behalf of National Multiple Sclerosis Society Virginia Consumer Action Network in support of Options III-A, III-B, and III-C. Ms. Cannaday stated, "Long term care residents and their families deserve the security of knowing that if the facility in which they reside decides to voluntarily close its doors, the residents will have the necessary time to find, choose and relocate to another high quality comprehensive facility without undo hardship."

Northern Virginia Aging Network

Erica F. Wood, Legislative Chair, commented: "NVAN supports the comments of the Jefferson Board for Aging, including JABA's request that the Joint Commission on Health Care seek a formal interpretation of 42 U.S.C. § 483.12 from The Centers for Medicare and Medicaid Services

concerning the requirement for notice in federal certified facilities. Pending this interpretation, NVAN supports the notice provision in Option II, as well as relocation provisions drawn from Option III [Options III-A and III-B]...."

Ms. Wood stated further: "In addition to and before reaching either Option II or Option III, the Commonwealth should begin a coordinated planning effort now, in order to best respond to voluntary or involuntary closures when they do occur. The Secretary of Health and Human Resources should coordinate state agencies and develop a focused and uniform approach for closure. This should include the State Long-Term Care Ombudsman Program, as well as VDH, DSS, VDA, DMAS, DMHMRSAS, Department for the Rights of Person with Disabilities"

TLC 4 Long Term Care

Ilene R. Henshaw, Director, Policy and Legislative Affairs, commented: "Although we believe that the system has, neither in regulation nor in practice, adequate meaningful protections for residents, we are unable to endorse any of the Policy Options offered in this Study at this time. We respectfully recommend that additional study, hearings and testimony are necessary in order to craft an effective and fair response to a nursing home closure....The voluntary closure of a nursing home is a decision that dramatically affects the lives of the frailest citizens of this Commonwealth who are being evicted from their only home. These individuals need and deserve a well-crafted legislative response."

Virginia Association of Area Agencies on Aging

Terri Lynch, President, Virginia Association of Area Agencies on Aging, commented: "We strongly support JABA's request that the Joint Commission on Health Care seek a formal interpretation of Title 42: Chapter IV, Sec. 483.12 from the Centers for Medicare and Medicaid Services....Because of the implications of the interpretation by CMS, we must however withhold our final comments on the three option choices in your study."

Ms. Bailey indicated opposition to Option II noting: "State agencies which oversee long term care facilities and resident rights recognize, and VHCA concurs, that there are times when it is in the best interest of residents to move them to a new facility as quickly as possible. When such circumstances exist, the move should not be delayed by a well-intended but counterproductive formal notice requirement." Further, Ms. Bailey stated: "We do not support A, B, and C of Option III because we do not believe the current state involuntary closure procedures must be placed in the Code of Virginia to give them effect."

Virginia Hospital and Healthcare Association

Susan C. Ward, Vice President, commented in support of Option I. Ms. Ward stated: "As the issue brief demonstrates, within the range of important challenges facing long-term care, anecdotal reports of occasional problems with voluntary closures of facilities do not represent an issue that requires legislative action. This is particularly true with regard to nursing facilities."

Ms. Ward also indicated that while VHHA prefers Option I, the Association "does not oppose Option 3D."

Ms. Ward stated that "VHHA opposes Option 2 for reasons that are well-articulated in the draft. It is neither reasonable nor in the public policy interests of the Commonwealth to force distressed facilities to remain in business longer than required by current federal law."

Virginia Long-Term Care Ombudsman Program

Joani Latimer, State Ombudsman, commented on behalf of the Virginia Long-Term Care Ombudsman Program in support of Options II, III-A, III-B, and III-C. Ms. Latimer indicated: "In light of growing concerns for the protection of dislocated residents, we would request that the Joint Commission explore whether one of the existing protections under federal regulations is being interpreted and enforced appropriately to maximize protections for residents of certified nursing facilities....[W]e would strongly encourage the Joint Commission, as part of the current study, to seek clarification of this regulation from the Center for Medicare and Medicaid Services....Irrespective of benefits that might be realized through a stricter interpretation and enforcement of federal protections, we believe there is still a need for legislation to ensure protection by those currently

unprotected in transfer/discharge situations. We assert that residents of assisted living facilities should be afforded equivalent protections in terms of improved notice and process, and that equivalent protections should be in place for closings, whether voluntary or involuntary."

JOINT COMMISSION ON HEALTH CARE

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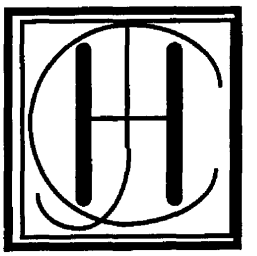
Senior Health Policy Analysts

Joseph J. Hilbert
E. Kim Snead

Office Manager

Mamie V. White



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