Missouri's Troubled Nursing Facilities

Executive Summary

Missouri's nursing home industry is in crisis, with widespread neglect, understaffing, and financial mismanagement putting vulnerable residents at risk. The sudden closure of Northview Village Nursing Home in December 2023, which displaced 170 residents, was a wake-up call to the systemic failures plaguing the state's long-term care facilities. This report identifies 68 "Troubled Nursing Facilities" across Missouri based on critical quality indicators, revealing alarming patterns of poor care, regulatory violations, and financial exploitation.

Key findings include:

- **Chronic Understaffing**: Many facilities operate with dangerously low staffing levels, leading to preventable resident harm, including untreated pressure ulcers, medication errors, and failure to respect end-of-life wishes.
- **Inadequate Supervision**: Lack of proper oversight has resulted in resident elopements, preventable accidents, and a disturbing prevalence of physical and sexual abuse.
- **Financial Misconduct**: Many nursing home operators divert Medicaid and Medicare funds through complex business structures, prioritizing profit over resident care.
- **Regulatory Failures**: Missouri ranks among the worst states for nursing home quality, with repeated citations failing to prompt meaningful improvements.

Recommendations for Reform

To address these critical issues, this report calls for:

1. Increased funding for the State Long-Term Care Ombudsman Program to improve resident advocacy.
2. Strengthened oversight of nursing home ownership transfers to prevent bad actors from taking over facilities.
3. Establishing a minimum direct care staffing requirement to ensure adequate resident care.
4. Conducting quarterly audits of staffing levels using CMS Payroll-Based Journal data to enforce compliance with staffing requirements.
5. Enhanced Medicaid cost report audits to prevent financial abuse.

6. A funding model that ties Medicaid reimbursement to actual staffing levels to ensure resources directly support resident care.

Missouri's long-term care system must be reformed to ensure the safety, dignity, and well-being of residents. Without decisive action, the crisis in troubled nursing facilities will continue to endanger thousands of vulnerable individuals across the state.

Introduction

On December 15, 2023, Northview Village Nursing Home, located in St. Louis and at that time the largest skilled nursing facility in St. Louis City, shut down unexpectedly, forcing all 170 residents to relocate to other facilities, some as far away as Viburnum, Missouri and Illinois. The tragic closure endangered residents and left a hole in the St. Louis region's long term care safety net. The chaotic and sudden nature of the closure shocked the public into paying attention to a long-overlooked component of the healthcare delivery system that is both invaluable to older adults and vulnerable populations but also employs a business model that "allows for money to be diverted away from care for residents and from nursing home workers to the pockets of owners and operators."[i]

The closure was less surprising to those who are familiar with the nursing home industry. Northview Village "had been fined 12 times for federal violations since March 2021" and incurred "fines totaled over $140,000",[ii] many related to short staffing. In the years, months, and weeks leading up to the closure, Northview's owners consistently short staffed the facility according to reports the facility submitted to Centers for Medicare and Medicaid (CMS). During the second quarter of 2023, the facility reported to CMS that it was providing, "a total of one hour 57 minutes of nursing care, 1.95 hours per resident day (HPRD) of nursing care, far less than the Missouri average of 3.3 HPRD."[iii] Prior to closure, revenues fell as fewer residents occupied available beds, yet expenses, including payments made to companies also owned by the facility's owners, or related parties, barely dipped.[iv]

The Northview Village tragedy exposed serious and prevalent issues at Missouri's nursing facilities that transcend geography and demographics. Throughout the state, problem operators use short staffing and related party payments to maximize profitability often at the expense of resident care. Dozens of Missouri facilities consistently failed to ensure resident safety. Legislators and regulators must act to protect residents.

This report establishes a criteria-based universe of Missouri's Troubled Nursing Facilities and provides an overview of some of the worst deficiencies at these facilities. This analysis demonstrates that the issues discussed here are experienced in rural, suburban, and metro areas. This is a statewide crisis and only a statewide solution can bring order and safety to the troubled long-term care industry.

Creating the Universe

Troubled Nursing Facilities are defined by the following criteria using the October 2024 Centers for Medicare and Medicaid Services (CMS) Monthly Nursing Home Dataset.

Criteria:

- One of the following:
    - CMS Overall Star Rating of 1 (star ratings include inspections, quality measures, and staffing)
    - Placement in the Special Focus Facilities Program designed for facilities with a history of serious quality issues
- Average Nursing Hours-per Resident Day < 3.48 (2024 CMS Staffing Floor)
- No Missing Data (many troubled facilities failed to report staffing data)

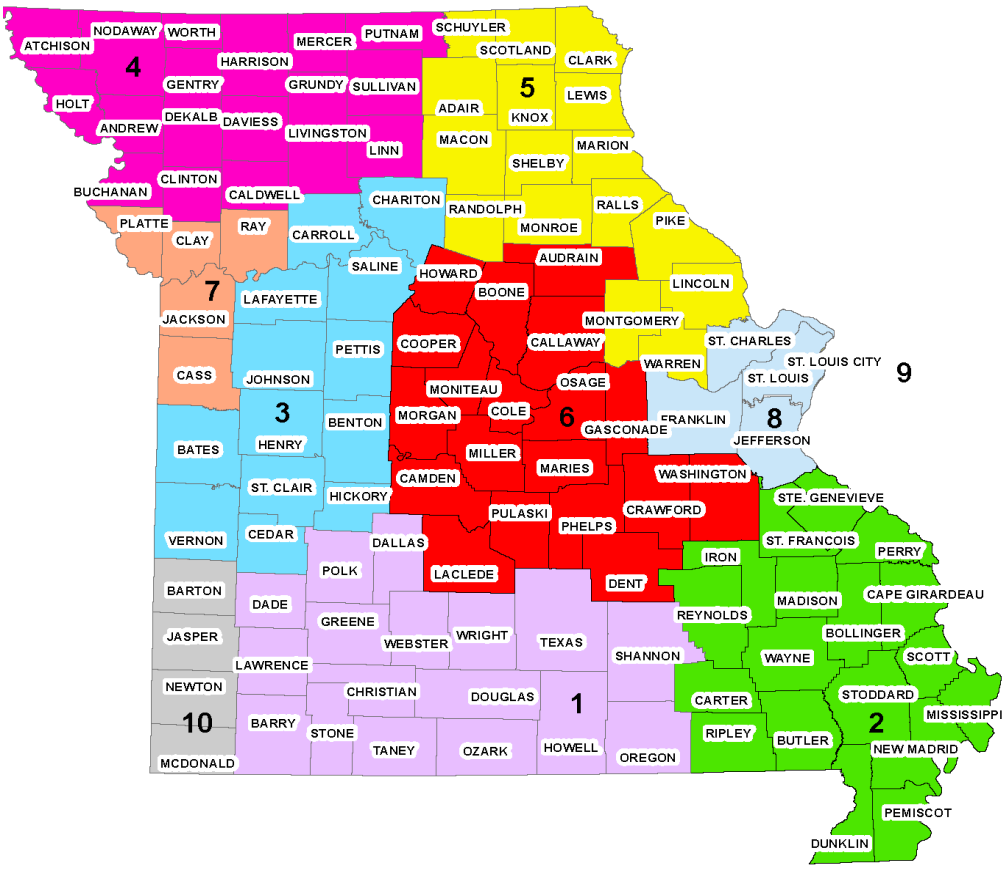
Applying these criteria created a Troubled Nursing Facility Universe comprised of the following characteristics:

- 68 Total Qualifying Facilities
- At Least One Troubled Nursing Facility per State Region
- Statewide Representation

Missouri has 161 one-star problem facilities, but 93 facilities failed to report staffing data and therefore are not included in our research

This universe of troubled facilities has much in common despite their disparate locations and resident demographics. Whether urban or rural, these facilities are typically understaffed, and many have received an Immediate Jeopardy citation from CMS during the last three-year inspection cycle. Immediate Jeopardy to one or more residents is the most serious citation a facility can receive from CMS. An Immediate Jeopardy citation can lead to termination from the federal Medicare and Medicaid programs. The citations run the gamut from deficiencies in resident care to inadequate supervision to prevent various forms of violence amongst and between residents. And as the following stories reveal, unsafe staffing to maximize profitability is often the culprit.

Troubled Nursing Facilities by State Region October 2021- October 2024							
State Region	Facilities	Number of Facility Reported Incidents	Number of Substantiated Complaints	Number of Fines	Total Dollar Amount of Fines	Number of Payment Denials	Total Number of Penalties
1	3	3	25	2	$ 26,328.00	2	4
2	2	13	20	18	$ 389,706.07	2	20
3	7	18	104	12	$ 238,659.10	7	19
4	6	6	82	7	$ 170,555.71	6	13
5	3	38	88	13	$ 859,435.85	7	20
6	4	4	22	25	$ 211,335.76	2	27
7	20	74	289	53	$ 1,190,694.78	10	65
8	18	56	771	72	$ 1,836,603.92	18	88
9	4	15	229	14	$ 564,508.28	2	16
10	1	3	3	1	$ 986.70	0	1
Total	**68**	**230**	**1,633**	**217**	**$ 5,488,814.17**	**56**	**273**



Resident Care

Missouri's Troubled Facilities chronically understaff to maximize profitability to the detriment of resident care. Facilities throughout the state have failed to competently treat pressure ulcers, prevent medication and clinical errors, and follow residents' code status.

Pressure Ulcers

A pressure ulcer, or 'bed sore', is an area of localized tissue damage caused by unrelieved pressure, friction, or shearing on any part of the body".[v] Pressure ulcers "cause pain, disfigurement, and increased infection risk and are associated with longer hospital stays and increased morbidity and mortality".[vi] They are extremely common in understaffed nursing homes. The CDC's landmark 2004 National Nursing Home Survey found that 11% of U.S. nursing home residents had pressure ulcers.[vii] Pressure ulcers also require frequent repositioning, meticulous wound care, and close monitoring, all of which are labor intensive.

Missouri's Troubled Nursing Facilities often fail to adequately treat pressure ulcers causing needless discomfort to residents. On June 6, 2024, CMS cited Joplin's NHC Healthcare after "the facility failed to provide pressure ulcer care and monitoring per standards of practice when staff failed to follow physician orders for treatment of an unstageable pressure ulcer to one resident's coccyx, failed to update the treatment after a visit to the wound clinic, and failed to complete a weekly assessment of the resident's pressure ulcer" resulting in hospitalization.[viii] Examination of the pressure ulcer "revealed a large, deep, gangrenous sacral decubitus ulcer, at least 10 cm in diameter, with dark, gray, gangrenous tissue throughout and a foul odor".[ix]

On January 4, 2022, CMS cited Redwood of Raymore, now named Sunrise Nursing and Rehabilitation, for failing to "accurately assess, document, and provide prescribed treatments" to a resident's pressure ulcers "resulting in the resident developing worsening wounds requiring amputation".[x] During the same inspection, CMS also cited the facility for failing "to provide adequate staffing to ensure residents attained the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and considering the number, acuity, and diagnosis of the facility's resident population".[xi] In order to address the violations listed, Sunrise pledged in its Plan of Correction to implement a new wage scale and retention bonus program to better recruit staff to prevent lapses in resident care.[xii]

Medication Errors

Failure to adequately treat pressure ulcers is far from the only resident care issue in Missouri's Troubled Nursing Facilities. Frequent medication errors cause needless pain and suffering to residents and can be fatal. According to the British Medical Journal (BMJ), "in the U.S. alone an estimated 800,000 preventable medication-related injuries occur every year in long-term care facilities and long-term care patients are probably subject to more medication errors on average than patients in acute care hospitals".[xiii] The BMJ listed "lack of time" often due to inadequate staffing and "frequent staff turnover" as top contributing factors to medication errors in nursing homes.[xiv]

Missouri nursing facilities, whether urban or rural, are rife with medication errors. In September of 2022, Westview Nursing Home in the tiny town of Center in Ralls County failed to ensure a resident was free from significant medication error when staff mistakenly injected the resident with the antipsychotic Invega Sustenna during three consecutive shifts causing the resident to develop dangerously low blood pressure that required emergency treatment.[xv] The following January the facility received a second Immediate Jeopardy citation for medication errors when staff failed to follow hospital discharge orders for two residents. In both cases, the facility "continued to give discontinued medication …, gave medications that were to be held and did not start new medications" resulting in one resident suffering a potassium overdose that required rehospitalization.[xvi]

In November of 2023, Lakeview Post Acute in suburban Florissant "failed to administer prescribed antibiotics, as prescribed by a physician, for a wound infection" for a resident with Stage II pressure ulcer who was also on an anticoagulated medication for an irregular heartbeat.[xvii] The facility's wound nurse mistakenly performed a debridement procedure on the resident's pressure ulcer causing them to bleed heavily from their wound. "No monitoring of the resident was implemented related to the increased risk for bleeding" and facility staff later "found the resident in his/her bed, bleeding from his/her wounds".[xviii] The facility called EMS and sent the resident to the hospital for treatment. According to CMS, "the resident's hospital admission diagnosis was hemorrhagic shock (caused by heavy bleeding, the heart can't get the blood and oxygen it needs to function), tachycardia (fast heart rate), and hypotensive (sic) (low blood pressure). The resident later died at the hospital."[xix]

Code Status

Missouri's Troubled Nursing Facilities too often misidentify residents' code status to tragic ends. In May 2024, staff at Aspire Senior Living Platte City failed to ensure that a "resident's code status was correct at the time of admission and carried out in accordance with the

guardian's directive".[xx] The resident's guardian directed staff on two occasions "to change the resident's code status to Do Not Resuscitate (DNR)".[xxi] When the resident stopped breathing, staff began CPR and contacted EMS who attempted to revive the resident against their wishes for more than an hour before declaring them deceased.

In December of 2023, CMS cited Aegis Health and Rehabilitation in Wildwood for failing "to provide CPR qualified staff for 28, 12-hour shifts" even though "thirty-eight residents were listed as full code (would want CPR administered)".[xxii]

Finally, in May of 2022 Oak Park Care Center in St. Louis "failed to immediately initiate basic life support" and "failed to immediately notify Emergency Medical Services (EMS) for one resident who was found unresponsive and was a full code (full support which includes CPR, if the patient has no heartbeat and is not breathing)".[xxiii] The resident passed away before staff realized their error.

By failing to adequately treat pressure ulcers, provide appropriate medication, and honor residents' code status, Missouri's Troubled Nursing Facilities cause residents' needless pain and suffering and even death.

Supervision

Missouri's Troubled Nursing facilities also fail to appropriately supervise residents resulting in misuse/overuse of restraints, resident elopements, and preventable accidents.

Misuse of Restraints

In November of 2023, regulators cited Reliant Care's North Village Park facility in Moberly for failure "to ensure residents were free from unnecessary physical restraints" and "failed to ensure chemical restraints were not used unless medically necessary" which regulators determined "increased the likelihood of residents experiencing serious physical and psychosocial harm".[xxiv]

Westview Nursing Home likewise received a citation in March of 2024 when "staff administered medication (that was not ordered to treat the resident's anxiety) to treat the resident's agitation".[xxv] Troubled nursing facilities like North Village Park and Westview often abuse chemical and other restraints as a cost saving alternative to adequate staffing and with the recent influx of residents with serious mental illness, misuse of restraints is becoming all too common even at better performing facilities.

According to the Long-Term Care Community Coalition's study on the use of chemical restraints in nursing homes. Chemical restraints, such as "antipsychotic drugs are a persistent staple of the nursing home drug regimen despite their risk of causing serious

physical and emotional harm to residents. AP drugs are associated with significant adverse outcomes in the elderly, including heart attacks, strokes, Parkinsonism, falls, and death. Numerous government interventions over several decades – from the 1987 Nursing Home Reform Law to the 2012 National Partnership to Improve Dementia Care – have aimed to mitigate AP drug use, but these potent drugs continue to flood nursing homes, inflicting immeasurable harm on residents and burdening the nation's long-term care system."[xxvi]

Elopement

Missouri's Troubled Facilities also struggle to prevent resident elopements. Regulators cited Troy Manor in Lincoln County, owned by James & Judy Lincoln, for failing "to provide one resident who had a diagnosis of schizophrenia and a history of elopement and exit seeking behaviors with sufficient supervision and monitoring to ensure the resident did not exit the facility without staff knowledge." In October 2022 after "staff left the resident's secured unit unattended for approximately 10 minutes, during which time the resident exited the facility".[xxvii] The resident was missing for seven hours before contacting family. The resident eloped again in December due to inadequate supervision and was unaccounted for until police "located the resident… walking down a busy four lane divided highway".[xxviii]

Crestwood Health Care Center in Florissant also received an Immediate Jeopardy citation for resident elopement in July 2022 when the facility "failed to ensure… protective oversight on three out of three secured units"[xxix] allowing multiple residents to exit without staff knowledge. One resident "reported he/she was assaulted" while away from the facility. Thankfully, none of these elopements resulted in a resident death as is sometimes the case.

Accidents

Lack of adequate resident supervision in Missouri's Troubled Nursing Facilities can cause preventable accidents resulting in resident injuries/deaths and is almost always attributable to inadequate staffing.

In February of 2024, Carmel Hills Wellness and Rehabilitation in suburban Independence "failed to ensure residents were free from accidents" when a CNA attempted to transfer a resident from their bed to a wheelchair without the use of a mechanical lift or the assistance of other staff.[xxx] The CNA lowered the resident to the floor causing injuries including "extensive swelling to the left knee, left ankle, left posterior thigh and right hamstring, and multiple fractures in the left knee/femur" that required hospitalization and "surgical intervention".[xxxi]

In August of last year at Rosewood Rehab and Healthcare Center, also in Independence; CMS cited the facility for failure to provide "adequate supervision and assistance" to a resident with "a diagnosis of dementia and known history of pulling his/her indwelling catheter". Staff failed to check on the resident overnight and the following morning "the resident was found lying on his/her side in a pool of blood, urine and feces. EMS pronounced the resident deceased. [xxxii]

Finally, Oak Park Care Center received Immediate Jeopardy citation as it "failed to ensure each resident receives adequate supervision to prevent accidents for on resident with a history of choking episodes".[xxxiii] The resident died after choking on a cupcake while the locked unit they lived in was left unattended.

As these incidents reveal, a lack of adequate supervision via adequate staffing can be deadly.

Violence and Abuse

Residents in Missouri's Troubled Nursing Facilities experience a profoundly disturbing amount of violence and abuse. Much of this violence and abuse, as with elopements and accidents, derives from these facilities' failure to provide enough staff to keep residents safe.

Violence

Resident violence is an increasingly common problem in Missouri nursing homes due in part to an influx of residents with a serious mental illness diagnosis and the nursing home operators' unwillingness to provide necessary training to prevent these incidents as well as their failure to ensure that enough staff are working.

In May of 2023, regulators cited Sunrise Nursing and Memory Care in Raymore for failing to ensure a resident "was free from resident-on-resident abuse" by allowing another resident to strike them on the head first with a trophy and then five days later with "a rock placed inside of a sock, resulting…in a laceration to the top of the head that required two staples".[xxxiv]

Gregory Ridge Health Care Center in Kansas City received Immediate Jeopardy citations for two instances of resident-on-resident violence in early 2024. In the first episode in February, a resident pushed staff aside, pulled a fellow resident to the floor, struck them in the face and head multiple times, and stomped on their head.[xxxv] In April, the facility failed to prevent a physical altercation between residents and staff resulting in multiple injuries.[xxxvi]

Finally, extremely troubled Senath South Health Care in the bootheel received multiple Immediate Jeopardy citations during the most recent three year inspection cycle for failure to prevent serious violent conflicts between residents including a stabbing and a murder by strangulation.[xxxvii] CMS determined that failure "to ensure sufficient and competent staff

to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being".[xxxviii] CMS eventually stopped providing funding through Medicaid and Medicare payments to Senath South Health Care in late 2024 and the facility was closed.

Resident-on-resident violence will continue to plague Missouri's Troubled Nursing Facilities until they employ sufficient staff and provide their staff with appropriate training to provide the necessary interventions for residents with violent impulses.

Sexual Abuse and Assault

Sexual violence is also a significant issue at Missouri's Troubled Nursing Facilities, which frequently house vulnerable residents with often residents with a history of inappropriate sexual behavior.

In September of 2022 at North Village Park, for example, regulators responding to a complaint determined that the facility "failed to report an allegation of rape to law enforcement".[xxxix]

At Westview Nursing Home in two separate instances in 2021 and 2022 the facility "failed to ensure one resident…was free from sexual abuse by another resident who had a known history of hypersexuality, sexually inappropriate behaviors and cognitive impairment". In both instances, a resident exposed themselves to another resident and intimately touched them without consent. [xl]

Parkview Healthcare likewise failed to ensure that a resident "was free from abuse when another facility resident was witnessed naked from the waist down on top of 'the resident' who was also found to have had his/her brief removed" in April of 2021.[xli] Further investigation revealed that the victim was a non-English speaking, severely cognitively impaired resident[xlii] who staff believed had been raped[xliii] by an HIV+ resident[xliv] .

In December of 2021, CMS cited Rosewood Rehab and Healthcare Center for allowing multiple sexual assaults amongst residents including several by a resident with "a history of aggressive sexual advances towards other residents".[xlv]

Sexual violence is a disturbingly common occurrence at Missouri's Troubled Nursing Facilities which the state should not allow to persist.

Self-Harm

In addition to resident-on-resident violence and sexual abuse and assault, Missouri's Trouble Nursing Facilities also fail to prevent resident self-harm. Again, inadequate staffing is often to blame. Troubled facilities refuse to staff sufficiently, putting patients with suicidal ideation at heightened risk with predictably tragic consequences.

In July 2024, for example, North Village Park "failed to provide protective oversight for one resident with psychiatric diagnoses, and a history of suicidal ideation" when the resident obtained a disposable razor from another resident and "cut his/her wrist several times".[xlvi]

Hillside Rehab and Healthcare Center received an Immediate Jeopardy citation in May of 2022 for failing "to provide assessment and mental health services for one…resident with a known history of suicidal ideation and attempts".[xlvii] The facility failed to prevent the resident from jumping out of a third-floor window in a suicide attempt. The attempt was nonfatal and caused the resident to suffer a broken back and two broken legs. Later that month, while recovering from their injuries, the resident made several additional suicide attempts by wrapping the call light cord around their neck.

Thankfully, neither resident died, but until Missouri's Troubled Nursing Facilities take the necessary preventative steps to address the underlying issues- such as ensuring residents receive appropriate mental health treatment, including timely psychiatric evaluations, appropriate medication management, and placement in inpatient psychiatric care when needed- residents will continue to attempt preventable self-harm.

Conclusion

Missouri's Troubled Nursing Facilities desperately need reform and additional oversight to better serve older adult and other vulnerable populations that require round-the-clock institutional care. For too long, operators like those featured here, have treated their facilities and residents as profit sinks rather than essential care providers and the results have been irrefutably tragic. Even more tragically, the problems discussed above are by no means limited to this universe of especially bad actors.

In 2023, AARP's Scorecard ranked Missouri as 38th in the nation for long-term services and supports for older Americans, weighed down heavily by rankings of 48th in Nursing Home Quality and 46 in Nursing Home Staffing Levels.[xlviii] Missouri ranks 52nd in the nation in number hours per resident per day in staffing with an average of 3.24 hours of care a day for a resident of a skilled nursing facility as of the second quarter of 2024. [xlix] Missouri has the fourth highest percentage of problem facilities in the US as of December 6, 2024,[l]

On the other hand, Missouri has many facilities where great care is provided for residents, where they are treated respectfully and with attention. Even in Troubled Nursing Facilities, there are residents, families, and staff working hard to turn them around. It is unfortunate that the acts and reputation of the operators of Missouri's Troubled Nursing Facilities tend to hurt the reputation of all of the facilities in our state, making moving to a nursing facility something to be feared by many of the state's residents.

As Missouri plans for a future where by 2060 older adults will outnumber minors,[li] the state must look for places to improve our ecosystem for those who need care.

Recommendations

Introduce and implement the following nursing home reforms.

1. Increase funding for the State Long-Term Care Ombudsman Program

The Long-Term Care Ombudsman Program provides advocates for residents of long-term care facilities to ensure resident rights are honored and resolve concerns regarding quality of care and quality of life. In 1995, the Institute of Medicine performed a national evaluation of the ombudsman program and found that 1 full time ombudsman per every 2000 beds should be the standard. This statistic has not kept up with the increasing complexity of complaints and resident needs. However, in the state of Missouri, the program has approximately one ombudsman for every 4500 beds, but in some parts of the state, that drops to one ombudsman for every 9000 beds due to funding distribution. $2.43 million in state appropriations is needed to bring the program in line with the 1995 standard.

2. Put various nursing facility transactions under Certificate of Need Law

Currently, Missouri statute requires "any person who proposes to develop or offer a new institutional health service within the state" to obtain a Certificate of Need. "Only those new institutional health services which are granted certificates of need shall be offered or developed within the state."

A Certificate of Need is not currently required, however, for "the transfer of ownership of an existing and operational health facility." This loophole has allowed unscrupulous nursing home owners, including private equity firms, to acquire nursing facilities throughout Missouri, degrading the quality of resident care and endangering nursing home workers and residents alike. A higher level of scrutiny is desperately needed.

Therefore, we propose to revise the law to require all institutional health services to obtain a Certificate of Need to transfer ownership of an existing healthcare facility.

2. Heightened ownership scrutiny in licensure application process

Nursing home owners often use complex business structures involving multiple corporations or LLCs per facility both to extract profits via related party transactions and to obfuscate their identities (and escape public scrutiny). Recently, and inspired explicitly by the proliferation of private equity in nursing home ownership, CMS announced a final rule that will require all nursing homes that accept Medicare or Medicaid to disclose all of their "owners, trustees, and companies that provide administrative, clinical, and financial services, including real estate investment trusts". We propose that Missouri adopt parallel disclosure requirements as part of the nursing facility licensing process.

3. Minimum direct care staffing required in licensure act

The CMS recently implemented a rule setting a minimum direct care staffing floor for all nursing facilities participating in Medicare or Medicaid. The rule requires nursing facilities to provide the equivalent of 3.48 hours of nursing care per resident day. However, a 2001 study commissioned by the federal government found that nursing home residents require at least 4.10 hours of care per day to avoid critical lapses in quality and safety. We propose that Missouri codify into state law a minimum direct care staffing rule of at least 3.48 hours of care per day and make it a condition of acquiring a license to operate a nursing facility in the state. Many states have such state-specific minimums required for licensure.

4. Quarterly enforcement of minimum staffing based on review of PBJ data

Implementing a new minimum direct care staffing floor will require additional enforcement. Thus, in addition to adopting the proposed minimum direct care staffing rule, we propose that the Missouri Department of Health and Senior Services. conduct quarterly audits of minimum direct care staffing based on a review of the Centers for Medicare and Medicaid Services' Payroll Based Journal (PBJ) system to determine whether nursing facilities are complying with the rule. We likewise propose to empower the Department to levy fines and penalties sufficient to ensure compliance. States that have this include Oklahoma, West Virginia and Illinois.

5. Implement consistent randomized audits of Medicaid Cost Reports

The Missouri Department of Senior Services- MO HealthNet Division should conduct regular randomized audits of Medicaid cost reports to ensure related party transactions are paid at fair market rates. This related party transactions can be used to misallocate Medicaid funds, diverting taxpayer dollars away from resident care. Without proper oversight, bad actors can manipulate cost reports to justify higher reimbursements while cutting corners on staffing, training, and services. Consistent audits would help prevent financial abuse, improve transparency, and ensure Medicaid funds are used to support high-quality care rather than maximizing profits.

6. Have part of the Medicaid rate depend on the ratio of actual direct care staffing to needed staffing

While Medicaid rates are calculated based on expected hours and minutes of direct care staffing required each day to meet residents' care needs, states commonly do not maintain any fiscal accountability on whether the Medicaid funds were actually used to deliver the needed care. We propose that the state make part of a facility's Medicaid rate based on a comparison of the Payroll Based Journal data on direct service hours actually delivered with the amount of hours for which the facility was paid, as used in the rate calculation.

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[ix] NHC Healthcare, Joplin, Statement of Deficiencies and Plan of Correction, Center for Medicare and Medicaid Services, Department of Health and Human Services, June 24, 2024, p. 13.

[x] Redwood of Raymore (Sunrise Nursing and Memory Care), Statement of Deficiencies and Plan of Correction, Centers for Medicare and Medicaid Services, Department of Health and Human Services, January 4, 2022, p. 1.

[xi] Redwood of Raymore (Sunrise Nursing and Memory Care), Statement of Deficiencies and Plan of Correction, Centers for Medicare and Medicaid Services, Department of Health and Human Services, January 4, 2022, p. 34.

[xii] Redwood of Raymore (Sunrise Nursing and Memory Care), Statement of Deficiencies and Plan of Correction, Centers for Medicare and Medicaid Services, Department of Health and Human Services, January 4, 2022, p. 51.

[xiii] Pierson S, Hansen R, Greene S, Williams C, Akers R, Jonsson M, Carey T. Preventing medication errors in long-term care: results and evaluation of a large scale web-based error reporting system. Qual Saf Health Care. 2007 Aug;16(4):297-302. doi: 10.1136/qshc.2007.022483. PMID: 17693679; PMCID: PMC2464957, https://pmc.ncbi.nlm.nih.gov/articles/PMC2464957/.
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[xv] Westview Nursing Home, Statement of Deficiencies and Plan of Correction, Centers for Medicare and Medicaid Services, Department of Health and Human Services, October 4, 2022, p. 57-58.
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[xix] Ibid.
[xx] Aspire Senior Living Platte City, Statement of Deficiencies and Plan of Correction, Centers for Medicare and Medicaid Services, Department of Health and Human Services, June 6, 2024, p. 1.
[xxi] Ibid.
[xxii] Aegis Health and Rehabilitation, Statement of Deficiencies and Plan of Correction, Centers for Medicare and Medicaid Services, Department of Health and Human Services, December 11, 2023, p.32.
[xxiii] Oak Park Care Center, Statement of Deficiencies and Plan of Correction, Centers for Medicare and Medicaid Services, Department of Health and Human Services, May 13, 2022, p. 1.
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