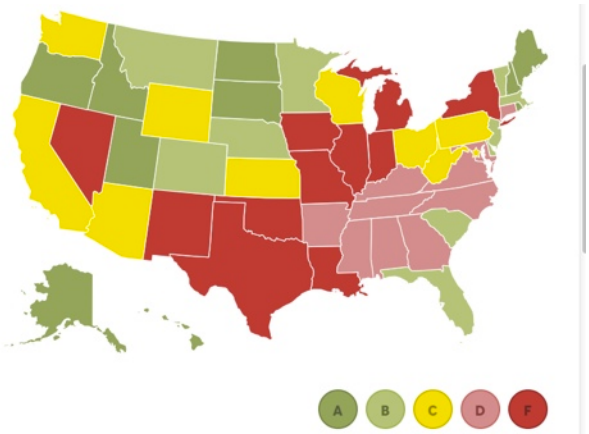
V O I C E S F O R Q U A L I T Y C A R E

A Report on the State of Nursing Homes Maryland 2013

Data in this report taken from the CMS Nursing Home Compare web site on November 21, 2013. Medicaid percentages are from 2012 and were provided by the Department of Health &Mental Hygiene -- Medicaid Division, Grade Card Information was taken from prior years information.

Maryland Nursing Homes receive a "D"



The Grading System:

Families for Better Care in Florida scored, ranked and graded states on eight different federal quality measures ranging from the percentage of facilities with severe deficiencies to the number of hours frontline caregivers averaged per resident per day.

Brian Lee, Families for Better Care's executive director, expressed his hope that the Report Card would help improve the quality of care.[1] "We're excited about getting this report into the hands of public officials, nursing home owners, advocates, and—most importantly—residents and their families," Lee said. "Our goal is to applaud those states that provide good care while motivating improvement for those that score poorly."

"A distinctive trend differentiated the good states from the bad states," Lee exclaimed. "States whose nursing homes staffed at higher levels ranked far better than those with fewer staffing hours." Maryland received no grade higher than a C in any of the 8 categories with a D in the categories of both Direct Care Staffing Hours and RN hours.

Overall, Voices for Quality Care supports this study and the Maryland findings. However, we note that the F in percent of Maryland Facilities with Deficiencies may well be attributed to above average diligence and competence in the Office of Health Care Quality, as opposed to similar agencies in other states.

Other key findings include:

More professional nursing staff is needed—Only seven states provided more than one hour of professional nursing care per resident per day.

An abundant lack of staffing—96 percent of states offered residents fewer than three hours of direct resident care per day.

Maryland Hours of Care per person per day—The Maryland minimum staffing requirements remain at 2.0 hours of care per person per day, below the 2.75 hours needed just to avoid harm and well below the 4.1 needed for good care

MARYLAND

Key Findings

- *Maryland's nursing homes consistently underachieved, failing to score an above average grade in any reviewed measure.*
- *Below average professional nurse hours and direct care staff hours contributed to a relatively meager percentage of deficiency free facilities.*
- *Maryland facilities were flush with regulatory problems as more than 90% cited a deficiency.*
- *Although Maryland scored a pedestrian ombudsman ranking, advocates still verified 3 out 4 registered complaints.*
- *Maryland is the worst nursing home state in the Mid-Atlantic Region.*

OVERALL GRADE	OVERALL RANK
D	34

CRITERIA	RAW DATA	GRADE	RANK
% Facilities With Deficiencies	95.22%	F	41
% Facilities With Severe Deficiencies	16.96%	C	24
Direct Care Staffing Above Average	61.71%	C	29
Direct Care Staffing Hours	2.37	D	36
Health Inspections Above Average	34.07%	C	29
RN Hours	0.72	D	38
RN Staffing Above Average	56.31%	C	28
Verified Ombudsman Complaints	74.12%	C	21

[1] **FOR MORE INFORMATION**: Brian Lee, *Executive Director* 850.224.3322 brian@familiesforbettercare.com

Let's First Congratulate Maryland's Best
We need more of these!

Nursing Homes with 3 or fewer health deficiencies in the last 36 months

Sacred Heart Home, Inc.
HillHaven Nursing Center
St. Joseph's Nursing Home
Crofton Convalescent Center
Garrett County Subacute Unit
The Green House at Stadium Place*
Calvert Memorial Hospital Transitional Care Unit

***The Green House at Stadium Place in Baltimore has only been in full operation for 1 cycle.**

Nursing Homes with 5-stars in all rating categories in the latest cycle

Nursing Home		OverAll	Survey	Quality	Staff	RN
CALVERT MEMORIAL HOSPITAL TRANSITIONAL CARE	Non profit	5	5	5	5	5
CRAWFORD RETREAT	For profit	5	5	5	5	5
MARIA HEALTH CARE CENTER, INC.	Non profit	5	5	5	5	5
NORTHWEST HOSP. CTR. SUB. UNIT	Non profit	5	5	5	5	5
PENINSULA REGIONAL MEDICAL CTR	Non profit	5	5	5	5	5
TRANSITIONAL CARE SERVICES AT MERCY MEDICAL CEN-	Non profit	5	5	5	5	5

We note that only 1 of the best performing nursing homes listed above, Crawford Retreat, is operated as a for-profit nursing home. The other 4 are operated as non-profits.

We are pleased to report that all but two of Maryland's Nursing Homes are now fully sprinklered as required by common sense and federal regulation. One that is still only partially sprinklered is Knollwood Manor Nursing Home in Millersville, owned by Steven Fishman, Robert Hartman, Arnold Whitman, Donna Reis 1995 Family Trust, FC-Gen Operations Investment LLC, Gazelle Gen LLC, Gen Management LLC, Gen Operations I LLC, Gen Operations II LLC, Genesis Healthcare LLC, Genesis MD Holdings LLC, Genesis Operations LLC, GHC Holdings LLC,, HCCF Management Group XI LLC, Senior Care Genesis LLC, Senior Care Holdings LLC, SL Gen LLC, ZAC Properties XI LLC. The other, Little Sisters of the Poor, is currently undergoing a full and extensive renovation. Sprinklers are being added as each section is completed.

And then resolve to fix the not so best.....

EXPLANATION OF RATING AND DEFICIENCY CATEGORIES	Scope of the Deficiency		
Severity of the Deficiency	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J	K	L
Actual harm that is not immediate jeopardy	G	H	I
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D	E	F
No actual harm with potential for minimal harm	A	B	C

The deficiencies in this report have been issued during the last three Survey Cycles. An annual survey is conducted in each nursing home. Citations of deficiency springing from that survey and all deficiencies resulting from investigations of complaints during the year are included in a cycle.

- Cycle 1 contains all citations of deficiency in the past 12 months.
- Cycle 2 deficiencies were issued 13-24 months previously.
- Cycle 3 deficiencies were issued 25-36 months previously.

The CMS nursing home Star Rating system awards a star rating based on health surveys, staffing levels, and quality measures.

- 1 Star = well below average
- 2 Stars = below average,
- 3 Stars - average
- 4 Stars = above average
- 5 Stars = well above average

Deficiencies which pose a serious threat if continued.

Level L Immediate Jeopardy deficiencies -- the worst of the worst

NURSING HOME	FOR PROFIT OWNERS/NON PROFIT MANAGERS
NMS Healthcare of Hagerstown, LLC	For-profit: Matthew Neiswanger, Jeffrey Renzuli, and Nancy Moore and Company, LLC
St. Thomas More Medical Complex	For-profit: Matthew Neiswanger, Jeffrey Renzuli, and Nancy Moore and Company, LLC

Level K Immediate Jeopardy deficiencies

NURSING HOME	FOR PROFIT OWNERS/NON PROFIT MANAGERS
Snow Hill Nursing & Rehabilitation Center* --(received 2 level K citations of deficiency in this cycle)	For-Profit: James Harrison, Jeffrey Harrison, Ellen Saunders, Chas Carlin Harrison Trust, Dylan Thomas Harrison Trust, Grace Whitney Saunders Trust, Harrison Godwin Saunders Trust, Mary C. B. Saunders Trust, Rose Valley Management, Salisbury Retirement Center Inc.

Level J Immediate Jeopardy deficiencies

NURSING HOME	FOR PROFIT OWNERS/NON PROFIT MANAGERS
Coffman Nursing Home	Non-Profit: Tara Hoffman: Managing Employee
Fort Washington Health & Rehabilitation Center	For-Profit: Steve Rosedale, Charles Stoltz, Ronald Wilheim, & OMG RE Leasing Co, LLC
St. Thomas More Medical Complex	For-profit: Matthew Neiswanger, Jeffrey Renzuli, and Nancy Moore and Company, LLC
South River Health & Rehabilitation Center	For-Profit: Steve Rosedale, Charles Stoltz, Ronald Wilheim, & OMG RE Leasing Co, LLC
Western Maryland Health System Frostburg Nursing & Rehabilitation Center	Non-Profit: Western Maryland Health System Corporation: Operational/ Managerial Control

ACTUAL HARM DEFICIENCIES IN MARYLAND NURSING HOMES

Deficiencies in which one or more people received actual injuries.

Level H Actual Harm deficiencies

NURSING HOME	FOR PROFIT OWNERS/NON PROFIT MANAGERS
Heritage Harbour Health & Rehabilitation Center	For-Profit: Murray Forman, Leonard Grunstein, Canyon Sudar Partners LLC, SAVASeniorCare LLC, SSC Equity Holdings LLC, SSC Subaster Holdings LLC, SVCARE Holdings LLC
Salisbury Center	For-Profit: Steven Fishman, Robert Hartman, Arnold Whitman, FC Investors XI LLC, FC-GEN Investments LLC, FC-GEN Operations Investment LLC, Gazelle GEN LLC, GEN Management LLC, GEN Operations I LLC, GEN Operations II LLC, Genesis Healthcare Ventures of Massachusetts Inc, Genesis Health Ventures of Salisbury Inc., Genesis Healthcare Holdings Inc, , GHC JV Holdings LLC, GHV At Salisbury Center Inc., HCCF Management Group XI LLC,PRLTC Inc, PRMC-GEC at Salisbury Center LLC, Salisbury JV LLC, Se Larts LLC, Senior Care Genesis LLC, Senior Care Holdings, LLC, SL Gen LLC, ZAC Properties XI LLC

31 Level G Actual Harm deficiencies were issued to Maryland Nursing Homes during the last Survey Cycle.

Nursing Homes with 2 or more 1-star ratings in the latest cycle

Nursing Home		Overall	Survey	Quality	Staff	RN
Envoy of Denton	For profit	1	1	4	1	1
Oakwood Care Center	For profit	1	1	4	1	1
Reeders Memorial Home	For profit	1	2	2	1	2
Snow Hill Nursing & Rehabilitation Center	For profit	1	1	2	2	4

*Nursing Homes with 60 or more citations of deficiency in the **last 3 cycles***

Nursing Home	# of Deficiencies
Rock Glen Nursing & Rehabilitation Center	83
ManorCare Health Services - Dulaney	74
Bel Pre Health & Rehabilitation Center	72
Ellicott City Health & Rehabilitation Center	71
Fairland Center	70
ManorCare Health Services - Bethesda	70
ManorCare Health Services - Rossville	70
Crescent Cities Center	67
Kensington Nursing & Rehabilitation Center	67
Springbrook Center	67
Fox Chase Nursing & Rehabilitation Center	63
St. Thomas More Medical Complex	61
Fayette Health & Rehabilitation Center	60

SIGNIFICANT NURSING HOME FINES IN MARYLAND ISSUED BY THE CENTER FOR MEDICARE & MEDICAID SERVICES[2]:

Heritage Harbor had 3 fines issued on 3/21/2013--$260, $24,505, and $130,000 for a total of $154,765.

Coffman Nursing Home had a fine issued on 7/24/2013 of $617,050.

Mid-Atlantic Chapel Hill had a fine issued on 9/11/2013 of 363,150.

National Comparisons

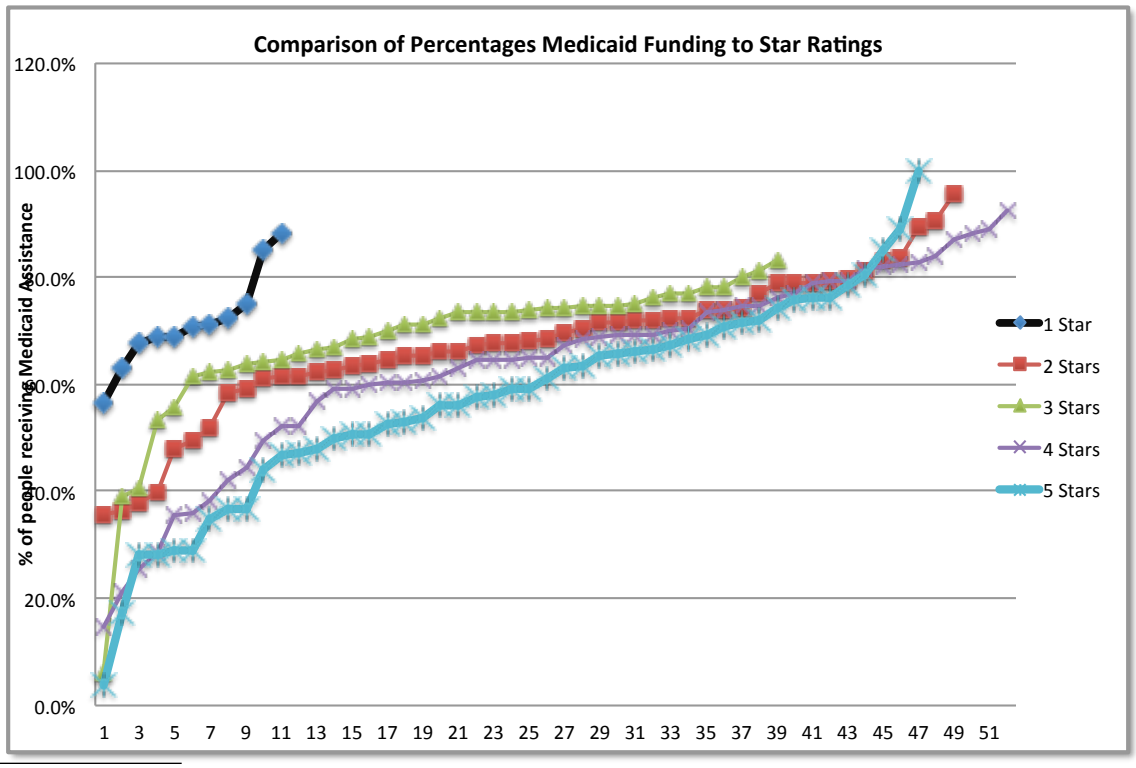
In hours of Geriatric Nurse Assistants' Care per person per day, Maryland ranks **38th** in the nation at a self-reported 2.39 hours. (The proposed new minimum staffing regulations only require 3.0 hours of care from nurses and aides combined. 3.0 hours per day are suggested for aides alone.)

Maryland ranked **43th** in the number of High Risk Long-Stay Residents with Pressure Ulcers. 7.1% of Maryland HIgh Risk Long-Stay Residents have pressure ulcers. This is an improvement from past years but is clearly still among the worst in the nation.

HOW DID WE GET HERE? HOW CAN WE FIX THIS?

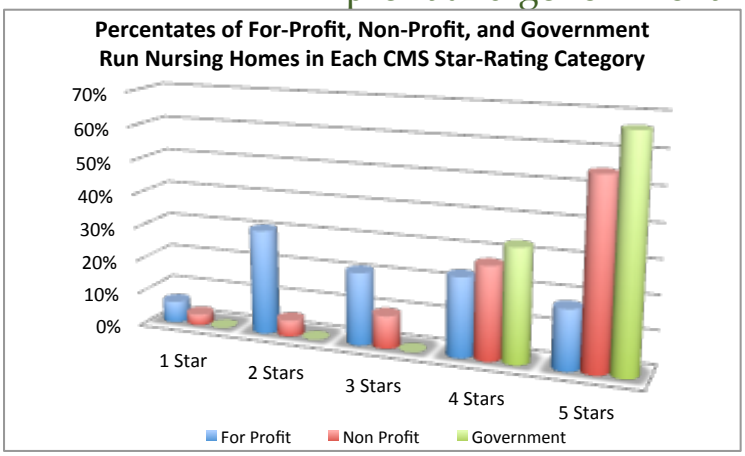
Is Medicaid Funding a Part of the Problem?

Statistics say "no". The chart below compares the percentages of people living in the nursing homes who are receiving Medicaid assistance with the CMS OverAll Star Ratings of the facilities. There is no apparent difference in the percentages of people on Medicaid in the Maryland's nursing homes and their CMS Star Ratings. There are nursing homes with higher percentages of Medicaid funding in the 4 and 5 Star categories than in the 1 Star category.



[2] This information comes directly from the Maryland Office of Health Care Quality (OHCQ).

Is the increase in for-profit nursing homes and the corresponding decrease in non-profit and government run homes a factor??



Statistics say "very likely". The chart on the left compares the percentages of for-profit, non-profit, and government run nursing homes in the various CMS Star-Rating categories. These numbers support the findings of many studies that have found that care in general is better in non-profit nursing homes. Voices would exclude those nursing homes with single owners, directly run by individuals or families, where the "profits" are basically the salaries of the owners who work in them.

SOME CAUSES, A FEW REMEDIES

One thing we need to admit is that nursing homes are not likely to reform themselves. Numerous efforts have been based on the premise that if we just teach them how to do things better, if we just encourage them to institute better practices, all will be well. The Advancing Excellence Campaign, for instance, was built on the premise of voluntary improvements. It has made little difference in the quality of care in our nursing homes so far. (The Maryland Advancing Excellence Campaign LANE is no longer meeting.)

STAFFING: The most critical factor affecting care in Maryland's Nursing Homes

Current: Minimum staffing regulations in Maryland remain at 2.0 hours of care per person per day. Despite continued efforts to bring minimum staffing regulations in line with the 4.1 hours studies indicate is necessary for good care, Maryland requirements remain far below even the 2.7 hours needed to prevent harm. The Senate Finance Committee most recently scuttled an attempt to remedy this. The Committee on the Oversight of Quality of Care in Nursing Homes and Assisted Living Facilities last addressed this issue in 2000 and has not discussed it since. Proposed new regulations from OHCQ would raise the minimum staffing to 3.0 hours per person per day including both nurses and aides, a level many states instituted and subsequently raised years ago, but would leave intact the current method of counting staff. This method requires counting staff and occupancy in the entire building for a 24 hour period and is so convoluted that few people living in our nursing homes or their friends and families can determine whether or not a nursing home is in compliance with the regulations. This compounds the problems arising from the fact that staffing levels are self-reported by the nursing homes and are not fully verified by any independent entity. New Proposed Regulations recently submitted for informal comments do little to remedy this situation. The only two changes are to change the minimal ratio of 1 caregiver to 25 people to 1 caregiver per 15 people and to change the hours of care from 2.0 to 3.0. In neither case are the licensed and support personnel clearly defined. The 3.0 hours itself is now an antiquated level when current recommendations are for 3.0 hours of Geriatric Aide care alone.

Solution: Raise the minimum staffing levels on every nursing home wing, unit, or floor and by shift to equal 4.1 hours per person per day in such a way that the people living in these homes, their friends and families, and the nursing home staff itself can quickly and easily determine whether these staffing levels are met. Then, determine direct care staffing levels from payroll, as required by the Affordable Care Act, not from self reporting. Level the playing field. Make the needs of the people who must live in nursing homes as important as the needs of the providers.

STAFFING AT OHCQ: Doing so much with so little.

Current: Staffing has increased somewhat in the past 2 years but is still nowhere near the level needed to fulfill the legal requirements and to properly regulate the facilities for which they are responsible. Surveys seem to be getting done nearly on time. Complaint investigations, from the reports we receive from the field, take so long that the complainants have forgotten some of the particulars of the complaint. If you call to complain that a dog is left without access to water for 8 hours or better, animal control in all areas of the state will usually investigate within 24 hours. If a person living in a nursing home is in the same situation, it can take months for OHCQ to send an investigator. If the person is subsequently admitted to a hospital suffering from dehydration and if the nursing home did not chart the lack of water, a complaint investigator will often determine it didn't happen, even with an Ombudsman as a witness.

Solution: The lack of an ability to provide a quick response to complaints regarded as trivial (no water to drink) means that many serious deficiencies in care and quality of life are not cited and not remedied. OHCQ needs to provide staff capable and ready to respond quickly. They should also be able to accept the word of another state official, ie. the Ombudsman, as a reliable witness on a par with an OHCQ Complaint Investigator.

OVERSIGHT COMMITTEE: **A mandate to monitor long-term care in Maryland gone awry.**

Current: We have a committee--created by state law--which is mandated to focus on improving quality of care in nursing homes. This committee meets quarterly but has never reviewed the status of nursing home care in Maryland in the last 10 years, let alone come up with recommendations for improving that care.

The committee is called the Oversight Committee on Quality of Care in Nursing Homes and Assisted Living Facilities. Its membership is made up of representatives from government agencies, providers of long term care services, and organizations of seniors and consumers. Brought together because of their knowledge of long term care, these members should be looking at staffing patterns in nursing homes and procedures for nursing home inspections and other issues mentioned in the law. Unfortunately, they have not be given the opportunity to do so.

Solution: The committee needs new leadership and a fresh approach to its work if it is ever going to decide on quality of care standards and recommendations to the legislature on how to fix our broken nursing homes.

OMBUDSMAN PROGRAM: **Federally Mandated Advocacy**

Current:. The Ombudsman Program has made considerable improvements in the past 6 years but still has a number of areas of concern. One of those concerns is advocacy regarding the actions of government agencies, legislation, policies, and other governmental operations. Beyond that, the Program is still erratic in the services it provides in various parts of the state. And, our Ombudsmen continue to struggle to maintain visits to nursing homes on a periodic basis when they are not responding to complaints. This Program does not have a conflict free attorney as required by federal law.

Solution: The Office of the State Ombudsman first and foremost needs considerably more recognition, respect, independence, and financing than it currently enjoys. One of the government agencies before which the Ombudsman Program is required to represent the interests of nursing home residents is the Department of Aging (MDOA). To be most effective, the Office should be moved out of its current location at MDOA to offices in Annapolis in order to be more independent and more centrally located. The number of local entities should be consolidated under the direct administration of the State Ombudsman with a full-time Local Ombudsman in each entity. Contracts or Memoranda of Understanding clearly outlining the entities' duties and responsibilities should be executed. A full-time paid Volunteer Coordinator should be added to the staff of the Office of the State Ombudsman to recruit, train, and help monitor Ombudsman Volunteers. Ombudsmen should make periodic visits to all nursing homes at times when they are not responding to complaints.

TITLE 42 > CHAPTER 35 > SUBCHAPTER XI > Part A > subpart ii > Sec. 3058f.

The Ombudsman ... shall, personally or through representatives of the Office - ***"represent the interests of the residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;"*** **and to** ***"analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other governmental policies and actions, that pertain to the health, safety, welfare, and rights of the residents, with respect to the adequacy of long-term care facilities and services in the State"***

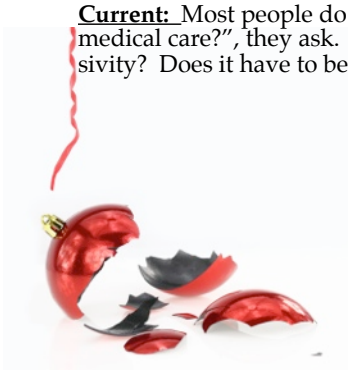
PROFITS & POLITICS: **An increasing factor in quality of life and care**

Current: More and more of our nursing homes are owned by REITs, Private Equity Companies, and Publicly Owned Corporations. Stock in nursing homes is considered a good investment. When federal & state funding levels are announced, nursing homes routinely complain that they will be driven out of business. At the same time, they also routinely report record earnings in their quarterly shareholder conference calls. Where are these profits coming from when 64% of the people living in Maryland's nursing homes are to some extent in the Medicaid Program?

Solution: Create a short but mandatory on-line course to bring non-profit and government run nursing home board members up to speed on regulations and best practices. Provide incentives and assistance to help these nursing homes remain non-profit or government run. Ensure that all "profits" in these homes are used for the care and welfare of the people living in the home.

CULTURE CHANGE: **Hope for the future**

Current: Most people do what they can to avoid nursing homes. "Why isn't quality of life just as important as quality medical care?", they ask. Does long-term care have to take place in a hospital setting, resulting in choicelessness and passivity? Does it have to be so dreary?



Solution: There is a cadre of reformers who want to change the way you think about nursing homes. This discussion of deinstitutionalization of long term care is called "Culture Change". Maryland has only one example of full Culture Change in practice: the Green House Residences at Stadium Place in Baltimore. Six to 12 residents live in private rooms in self-contained units, each with an open kitchen and living room with fireplace.

But culture change is about much more than redesigned living space. It is about changing values, goals, and roles. How to get nursing home administrators to focus on happiness of residents as well as health and safety? How to get nursing staff to focus on relationships as well as care-giving tasks?

This year has seen the creation of the Maryland Nursing Home Culture Change Coalition. The coalition is made up of consumers, academics, ombudsmen, and long term care providers. The coalition will work to spread the word on Culture Change and get all Marylanders to imagine a new future for nursing homes. This is a beginning.

ADMINISTRATOR TRAINING AND RECYCLING: **Additional data required**

Current: Voices has observed how important the leadership of the Administrator is to the quality of care and life of people living in nursing homes. For nursing homes to be able to hire good administrators, there must be a healthy pool of good candidates. As of January 24, 2014, the Executive Director of the State Board of Examiners of Nursing Home Administrators, Patricia Hannigan, said there are currently 527 administrators licensed in Maryland, the lowest total number in recent years. There are 233 administrators working in Maryland's nursing homes, supposedly leaving 294 available. Although she could not furnish any numbers, Hannigan said the pool of available administrators is decreased by a number of factors:

1. Administrators maintain their licenses after they retire. A number now are more than 80 years old.
2. Several facilities have more than one administrator. One even has 4.
3. Directors of Nursing will sometimes become licensed as administrators, but continue to work as Directors of Nursing.
4. People get hired almost as soon as they pass the exam and complete their work study requirement.

Hannigan estimates that there are fewer than 200 administrators actually available for work, but has no knowledge of who those people are. She noted that there are presently 6 candidates for administrator who have been unable to identify a preceptor, even if they are willing to work for free.

Solution: The State Board of Examiners of Nursing Home Administrators needs create a list of licensees available for work, and include in that list the star ratings and total number of deficiencies in the homes they administer for at least the last 3 years.

DEMENTIA & MEMORY CARE TRAINING FOR STAFF: **It's about time**

Current: Dementia and Memory Care units are a popular item these days, but in some cases the difference between these units and other long-term care units is simply locked doors. Quality of life is as important as quality of care and in some cases more so in these units. They require specially designed environments, activities, staff scheduling, and staff training. Conditions causing dementia may also cause a number of personality changes leading to unnecessarily troublesome behaviors which can escalate to a dangerous level if staff is not trained to diffuse and distract properly. There is also an issue affecting relative few people in which a person suffering from a temporary condition that causes delirium or other symptoms of dementia is inappropriately confined in a dementia unit.

Solution: We need a clear description of the things necessary to label a Dementia Unit or Memory Care Unit as such with requirements for each element enforced. Staff needs training in methods of de-escalating and redirecting behaviors that could cause issues with residents, staff, or others before the issues become critical. This training needs to be clearly evident at all times. Additional staff as well as altered staffing patterns, particularly on the night shift, need to be regulated. If they intend to have Dementia & Memory Care Units, nursing homes need to take responsibility for handling the symptoms these syndromes produce rather than laying the results entirely on the shoulders of the person so afflicted. Proof of diagnosis, guardianship, power of attorney, and care plan need to be readily available at all times to all staff members working with people living in these units particularly where they are locked units.

Other Serious Issues

The MOLST form: As of April 1, 2012, every person who lives in a nursing home is required to have a Medical Orders for Life Sustaining Treatment (MOLST) form filled out by the nursing home and signed by a physician or nurse practitioner. This form is the basis for decisions about whether and how to resuscitate. Voices has discovered MOLST forms that seemed to be filled out based on a conversation with an incompetent patient and without notifying that patient's health care representative. Some contain instructions contrary to the those of an incompetent person's health care representative. Some were never filled out at all or were filled out without issuing a copy to an incompetent person's health care representative. Most of these problems could have been prevented if the nursing homes simply complied with the part of the law that requires giving a copy to the patient or the patient's health representative. Since that is not happening, the law should be amended to require a signature from the patient or patient's health representative as to the compliance of the information on the MOLST form with the person's wishes as is happening in most other states. This is not a situation where do-overs are effective.

Bed Hold: Maryland, the state with the highest per capita income in the nation, should not need to save money by refusing to pay to hold the bed for a reasonable time for someone on Medicaid and living in a nursing home who needs a short hospital stay. For people living in nursing homes, it is their home in the same way your home is yours. Their "stuff" is there. The people they now know are there. Imagine the fear that comes from knowing that if you need hospitalization, someone will come into your house, pack up all of your belongings, and move you to a place you did not choose and that you've never seen. Consider then the poor folks who are now at the end of life. They often require several brief hospitalizations. Under this policy, each hospitalization opens the possibility of an additional move and each move creates an additional layer of transfer trauma. We are better than this!

One survey report for a citation of deficiency noted that there was no MOLST form, the patient was incompetent, and a nurse "discovered" her admission notes on the patient's desires about an hour after the surveyor requested them. There is no record of anyone having talked to the family.

Conclusion

The quality of nursing homes has not been a priority in Maryland and the people who must live in them have suffered for this. Even the committee created to provide oversight for them has not investigated the issues affecting the quality of care in these homes and has made no effort to formulate guidance principles or to make recommendations for improvements. The Office of Health Care Quality, the only agency with the authority to go into a nursing home and require them to remedy poor care, has been chronically underfunded and understaffed for at least the last 20 years. The Ombudsman Program was allowed to disintegrate to the point that it was in direct conflict with federal law. It is just now, after a great deal of work, beginning to recover. We are losing our community nursing homes to homes owned by and run by remote entities whose primary interest is profit, not care. Maryland deserves better.

It does not have to be this way. If together we embark on a journey to honestly evaluate the performance of our nursing homes with the intent of resolutely insisting on effective remedies for less than stellar performance, we can make Maryland's nursing homes the standard others hope to achieve. Our people deserve this.

We deserve better!

We can be better!

Let's do it!