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Nursing Home Receiverships: Design and Implementation

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NURSING HOME RECEIVERSHIPS: DESIGN AND IMPLEMENTATION

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I. INTRODUCTION

The precarious psychological and physical condition of most nursing home residents[1] demands strict and swift enforcement of the legal standards governing nursing home care and safety.[2] Nevertheless, enforcement must be both deliberate and cautious. The very circumstance that demands swift enforcement makes such actions dangerous when resident transfer is necessary.[3] Furthermore, even

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1. The average nursing home resident is 82 years old, female and widowed with no viable relationships except a collateral relative of approximately the same age. She receives few visitors. She suffers from four chronic or crippling diseases and some degree of mental impairment. She cannot walk and probably needs help in taking a bath and dressing. She is afraid. Only four to 19 percent of those entering a nursing home get out alive. *Nursing Home Access: Making the Patient Bill of Rights Work*, 54 J. URB. L. 473 (1977) [hereinafter cited as *Nursing Home Access*]. More than one-half of all nursing home residents need help in walking and bathing; almost one-half need help in dressing; and more than one in 10 needs help in eating. *Nursing Homes* (Nov. 1978) (unpublished newsletter of the Nat'l. Senior Citizens Law Center).

2. Nursing homes participating in the federal reimbursement programs of Medicare and Medicaid under 42 U.S.C. §§ 1395-96 (1976 & Supp. III 1979) are regulated by federal law as to standards of care and structural safety, among other items. Because Medicaid is the most frequent source of primary payment for nursing home care, the impact of federal regulation of nursing homes has been extensive. Medicaid has contributed to a tremendous growth in reliance on nursing home care. Between 1960 and 1970, the number of nursing homes increased by 140%, the number of beds by 232%, and the number of patients by 210%. Federal expenditures for long-term care increased from $500 million in 1960 to $7.5 billion in 1974. SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, S. REP. NO. 93-1420, 93d Cong., 2d Sess. 20-21 (1974). Federal regulation also has set the pattern for the standards in state laws. A typical example is the incorporation of the federal patient's bill of rights, 42 C.F.R. §§ 405.1121(k), 442.311(c) (1979), in the new Missouri Omnibus Nursing Home Act. MO. REV. STAT. § 198.088 (Supp. 1980). The reformed state laws have emphasized the development in innovative enforcement mechanisms, including the statutory receivership discussed in this article. *State Nursing Home Laws—Innovative Enforcement Mechanisms* (July-Aug., 1978) (unpublished newsletter of the Nat'l. Senior Citizens Law Center).

3. Studies of transfers of elderly nursing home residents have consistently found that sudden involuntary transfer of residents results in a dramatic increase in the death rate. Studies have reported that the death rate of residents transferred sud-

though the nursing home industry has been the subject of well-publicized scandals, the demand for beds far exceeds the supply.[4] Even the most zealous nursing home reformers have been hesitant to enforce standards requiring the closing of the facility in the face of continuing shortages of nursing home beds.

Sanctions of decertification for Medicare-Medicaid eligibility on the federal level[5] and license revocation or denial on the state level[6] have been ineffective remedies. Years of litigation and appeal, in effect, postpones effective impositions,[7] and enforcement usually requires the facility to close.

What is needed, therefore, is an interim measure to protect the health and safety of the residents and the property of the owner until there is a final determination of the appropriate sanctions or until the facility has complied with standards. Even in cases in which the residents must be transferred quickly to another facility[8] it is necessary to maintain the facility while the residents are safely transferred. Moreover, in most cases of substandard operations, the status quo should be maintained and necessary improvements should be made for the health and safety of the residents. Additionally, actions should be taken that can prepare the facility for continued existence.

As shown in Section II of this article, the statutory receivership

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denly with no preparation increased by 100%, 500%, and up to 900% over the rate for other institutionalized persons of the same age group. *See generally* Schulz and Brenner, *Relocation of the Aged: A Review and Theoretical Analysis*, 32 J. GERONTOLOGY 323 (1977). This phenomenon is widely accepted and has led to the passage of statutes requiring owners, operators, or receivers to prepare residents for transfer. *See, e.g.*, MO. REV. STAT. § 198.112(13)-(16) (Supp. 1980). Justice Stevens for the majority in O'Bannon v. Town Court Nursing Center, ____ U.S. ____, 100 S. Ct. 2467, 2475 (1980), stated that "we assume for purposes of this decision that there is a risk that some residents may encounter severe emotional and physical hardship as a result of a transfer." This assumption was based on studies cited by the nursing home patients in their brief. The district court did not take any evidence concerning transfer trauma.

4. *See* Note, *Medicaid Recipients' Access to Nursing Homes: Reflections On The New Jersey Approach*, 24 ST. LOUIS U. L. J. 806 (1981).

5. 42 C.F.R. §§ 405.604, .614 (1979).

6. State law regulates licensing standards and procedures for nursing homes.

7. Once a state administrative agency revokes the operating license of a facility, the facility has the opportunity to pursue administrative appeals and then seek judicial review, during which time the revocation is stayed and the facility continues to operate. A 1973 report by the California Deputy Attorney General indicated that license revocations in that state had been pending for as long as five and seven years. Cohen, *Long-Term Care: A Challenge to Concerted Legal Techniques*, 2 OHIO N. L. REV. 642, 667 (1975) [hereinafter cited as *Long-Term Care*].

8. Immediate transfer is required when the owner does not contest the penalties and decides to close the facility or when the violations are so severe as to threaten the lives of the residents.

provisions[9] in several recently reformed state nursing home laws[10] hold the most promise for effective enforcement of standards while also protecting residents from life-threatening transfers and preventing facilities from closing. The receivership resolves the inadequacies of the more drastic remedies of license revocation and decertification. Although the court may appoint a receiver to close a facility after he adequately prepares the residents for transfer, it may, more importantly, direct him to upgrade permanently the standards at the home, and thereby contribute to the supply of quality nursing home beds, rather than aggravate the acute shortage.

The potential for statutory receivership is well illustrated in the case of the Village Nursing Home in New York City, which, in 1976, was one of the first nursing homes to be placed under statutory receivership. Section III of this article documents the course of events surrounding the progress of that home from a substandard facility

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9. The equitable receivership is within the inherent equity power of the court. The receivership traditionally has been used to preserve assets in dispute during the pendency of litigation. The courts have used equitable receiverships to enforce public rights. For example, in *Turner v. Goolsby*, 255 F. Supp. 724 (S.D. Ga. 1966), the court appointed a receiver for a public school system to facilitate desegregation. The transformation of the common law receivership into a statutory tool with the primary purpose of protecting public health and safety, while attempting to preserve property rights, was encouraged by the New York statute on receiverships for substandard housing. N.Y. MULT. DWELL. LAW § 309 (4), (5) (McKinney 1974). Additional encouragement was provided in the subsequent report of the bill's successful implementation in Comment, *Receivership of Problem Buildings in New York City and Its Potential for Decent Housing of the Poor*, 9 COLUM. J. L. & SOC. PROB. 309 (1973). Health care facility regulation is analogous to public housing regulation in that both involve activities which, although often private or proprietary, are imbued with a sense of public purpose. The quality of housing and health care clearly affects public health and safety. In both areas, the enforcement of regulations is difficult because elderly consumers have limited access to attorneys, alternative care, and housing. A statutory "medical receivership" was first proposed in 1971 in *Grad, Upgrading Health Facilities: Medical Receiverships as an Alternative to License Revocation*, 42 U. COLO. L. REV. 419 (1971). New York enacted a statutory receivership provision for nonprofit facilities in 1968. N.Y. PUB. HEALTH LAW § 2862(4) (McKinney 1977). Several authors thereafter suggested that the receivership be developed for use for nursing homes. *See Long-Term Care, supra* note 7, at 666-68. New York's enactment in 1975 of receivership provisions for residential health care facilities, which include nursing homes, was praised widely. *Receivership and Nursing Homes* (Oct., 1977) (unpublished newsletter of the Nat'l. Senior Citizens Law Center). *See also Nursing Home Access, supra* note 1; Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304 (1975).

10. *See, e.g.*, CONN. GEN. STAT. ANN. § 19-621a (West Supp. 1980); KAN. STAT. ANN. § 39-354 (Supp. 1979); MINN. STAT. ANN. §§ 144A.14, .15 (West Supp. 1981); MO. REV. STAT. §§ 198.099 to .136 (Supp. 1980); N.J. STAT. ANN. §§ 26:2H-38, :2H-47 (West Supp. 1980); N.Y. PUB. HEALTH LAW § 2810 (McKinney 1977); WIS. STAT. ANN. § 50.05(4) (West Supp. 1980).

threatened with closing to a prototype of a high quality, community-based nursing home. Section IV develops a model for the effective use of the receivership in nursing home reform.

II. BACKGROUND: THE STATUTORY NURSING HOME RECEIVERSHIP

This section will consider the recently enacted statutory receivership provisions of Minnesota,[11] Missouri,[12] New Jersey,[13] and New York.[14] Provisions of major interest include a party's eligibility to petition for receivership, the grounds needed to support the appointment of a receiver, and the powers granted to a receiver. These factors influence the degree to which the receivership will be used, the willingness of qualified private parties and government agencies to become receivers, and the potential of the receivership to effect a stable continuation of the facility. Because the statutory nursing home receiverships are descendants of the equitable receivership extant in the common law power of courts of equity,[15] the principles of equitable receivership offer an effective guide to the interpretation and implementation of the nursing home receivership provisions.

A. *Petition*

In all four state statutes, the owners of the facility may voluntarily petition the court for the appointment of a receiver. The coordinated use of less drastic remedies, such as civil fines,[16] may lead the operator of a substandard home to petition for a voluntary receivership. The obvious advantage of this approach is that it does not require proof of the specific, often narrow, statutory grounds warranting a receivership.[17]

In the absence of a voluntary petition by the owner, all four states[18] place primary responsibility for invoking the receivership upon the state agency that enforces nursing home regulations and, in the case of Missouri, alternatively upon the Attorney General.[19] In

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11. MINN. STAT. ANN. §§ 144A.14, .15 (West Supp. 1981).
12. MO. REV. STAT. §§ 198.099 to .136 (Supp. 1980).
13. N.J. STAT. ANN. §§ 26:2H-38, :2H-47 (West Supp. 1980).
14. N.Y. PUB. HEALTH LAW § 2810 (McKinney 1977).
15. The courts have used their inherent equitable power to appoint receivers for nursing homes. *See, e.g.*, In Re Brookhollow Associates, 575 F.2d 1003 (1st Cir. 1978); Toler v. Lula Toler Convalescing Home, 364 S.W.2d 680 (Ark. 1963).
16. MINN. STAT. ANN. § 144A.14 (West Supp. 1981); MO. REV. STAT. § 198.099 (Supp. 1980); N.Y. PUB. HEALTH LAW § 2810(1) (McKinney 1977).
17. *See* text accompanying notes 26-34 *infra*.
18. MINN. STAT. ANN. § 144A.15(1) (West Supp. 1981); N.J. STAT. ANN. § 26:2H-38 (West Supp. 1980); N.Y. PUB. HEALTH LAW § 2810(2) (McKinney 1977).
19. MO. REV. STAT. § 198.099 (Supp. 1980).

addition, the Missouri[20] and New Jersey[21] statutes permit a resident or the guardian of a resident to petition the court for the appointment of a receiver. Such provisions represent a significant advance over the common law, which has not always looked favorably upon the residents' standing to sue.[22]

Nursing home residents and their families are the persons most likely to be familiar with conditions within the facility[23] and are also most likely to suffer direct injury through the substandard operation of the facility. The only argument against allowing residents and their families or guardians to petition the court directly for a receiver is the fear that residents may harass the owners with frequent and unsubstantiated suits. This argument is weakened, however, by the very nature of the relationship between a nursing home resident and the institution; that relationship militates against any legal action by the resident or his family. The typical nursing home resident depends on the institution for his basic daily needs,[24] a factor which may lead to fear of retaliation. This fear limits the initiation of suits by nursing home residents. Families also hesitate to complain, not only because of fear of retaliation against the resident, but also because of the guilt they feel after placing a family member in a nursing home.

The New Jersey receivership statute protects the owner of the facility from frivolous suits by requiring the petitioner to show that the conditions have been brought to the attention of the owner of the facility and that the owner has either failed to remedy the problem within a reasonable period of time, or that a pattern or practice of periodic, but temporary, remedies exists.[25] While these requirements protect the owner, they do not create a serious obstacle to legitimate challenges by residents and, therefore are, potentially satisfactory resolutions.

B. *Grounds*

The grounds supporting the appointment of a receiver, in the absence of a voluntary petition by the owner, vary considerably among the states. Minnesota allows receivership only when the Commissioner of Health has "commenced license suspension or revocation proceedings, suspended or revoked a license, or decided not to

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20. *Id.*

21. N.J. STAT. ANN. § 26:2H-38 (West Supp. 1980).

22. *See, e.g.*, MO. REV. STAT. § 198.093 (Supp. 1980); N.Y. PUB. HEALTH LAW § 2801-d (McKinney 1977); W. VA. CODE § 16-5C-15(c) (1979). *See also* Johnson and Hoffman, *Missouri's Omnibus Nursing Home Act,* 26 ST. LOUIS B. J. 4, 8 (1980).

23. The importance of consumer action and community interest in nursing homes is well noted in *Nursing Home Access, supra* note 1.

24. *See* note 1 *supra.*

25. N.J. STAT. ANN. § 26:2H-39(b) (West Supp. 1980).

renew the nursing home license."[26] New York allows an involuntary receivership only when the Commissioner of Health "revokes the operating certificate [license]"[27] of the facility. In that situation, the New York statute requires the Commissioner to apply for a receivership. New Jersey is the most liberal of the states, allowing the appointment of a receiver when there is "substantial violation"[28] or a "pattern and practice of habitual violations" of federal or state standards or "any other" conditions dangerous to life, health, or safety.[29] The Missouri statute lists seven grounds for receivership including operating without a license and closing the facility without adequate arrangements for relocation of residents. Moreover, insolvency of the owner of the land or structure, when such insolvency substantially affects the operation of the facility, and an emergency within the facility[30] are also grounds for receivership.

Each of the statutes presents difficulties in interpretation and implementation. The Minnesota provision allows the appointment of a receiver only in cases in which the state license is revoked or denied. This requirement is too narrow. Even if one accepts the underlying presumption that receiverships are reserved for situations in which the continued existence of the facility is in imminent danger, the statute ignores similar situations that threaten the facility with closing, such as decertification of participation in federal reimbursement programs. This type of decertification occurs in a number of situations including when an operator decides to close the facility voluntarily, or when a facility faces insolvency or bankruptcy. In both situations the threat of closing may cause the residents to suffer transfer trauma. If there is time to plan for new ownership and administration, the facility also may be retained in the original neighborhood. In either case, a receivership would be a useful way to ensure that the closing is not precipitous.

For all the nearsightedness of the Minnesota statute, the New York statute is even more narrow. The New York provision, which apparently limits the involuntary receivership to a situation in which the Commissioner revokes the license of the facility, must be interpreted to encompass the entire revocation process from notification of the owner through final revocation. If "revokes" is interpreted in a different manner, the effectiveness of the receivership in protecting the health and safety of the residents, and in avoiding the loss of nursing home beds, is minimal. An effective receivership should facilitate planning for the future. However, the planning details take time to develop and install.

26. MINN. STAT. ANN. § 144A.15(1) (West Supp. 1981).
27. N.Y. PUB. HEALTH LAW § 2810(2) (McKinney 1977).
28. N.J. STAT. ANN. § 26:2H-38 (West Supp. 1980).
29. *Id.*
30. MO. REV. STAT. § 198.099 (Supp. 1980).

New Jersey and Missouri have taken opposite approaches to expanding the grounds for receivership. New Jersey has chosen to create broad, though not specific, grounds, which include "substantial violation," "habitual violation," or "any other conditions dangerous to life, health, or safety." Missouri has specified seven grounds, leaving only "emergency" defined in nonspecific terms.[31]

The broad language of the New Jersey statute allocates decisionmaking to the courts; the more specific language of the Missouri statute reflects a desire for legislative control. In other words, because New Jersey has stated the grounds supporting the appointment of a receiver in general terms, subject to differing interpretations based on the degree to which violations have become "habitual" or "substantial," the court has greater discretion in deciding whether those grounds have been met in a particular set of facts. Missouri's statute, with the exception of "emergency," specifies grounds that are easier to prove in a particular fact situation. For example, no discretion is possible in deciding whether a facility is operating without a license.

Although it would appear that the New Jersey approach would allow receiverships in more cases and allow the courts greater flexibility, the historical limitations to the doctrine of equitable receivership may guide New Jersey courts to an even more limited use of the receivership provisions than is exercised by courts in Missouri. Because the equitable receivership is considered a drastic remedy of last resort,[32] and because the receivership statutes generally require court supervision of the daily administration of the facility,[33] proponents of receiverships may find courts reluctant to order one in all but the most extreme situations. A recommendation as to which approach is preferable must be made, therefore, on the basis of a judgment whether allocation of decisionmaking to the court will accomplish or thwart the goals of the receivership.

The New York, Minnesota, and Missouri statutes all rely on grounds for receivership that limit the appointment of the receiver to situations in which the facilities are likely to close and which,

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31. The statute defines emergency as "a situation, physical condition or one or more practices, methods or operations which presents imminent danger of death or physical or mental harm to residents of a facility." MO. REV. STAT. § 198.006(6) (Supp. 1980).

32. Bracco v. Lackner, 462 F. Supp. 436, 456 (N.D. Cal. 1978); *See also* Rockhill Care Center, Inc. v. Harris, No. 80-CV-W-6 (W.D. Mo., filed Dec. 1, 1980) (citing *Bracco v. Lackner* in the context of a nursing home receivership).

33. All receiverships require court supervision. The statutory receiverships may mandate particular types of supervision. For example, the Missouri statute requires court approval of any expenditure over $3,000 or some other amount set by the court. MO. REV. STAT. § 198.112(3) (Supp. 1980).

therefore, present a danger of sudden transfer to the residents.[34] New Jersey, on the other hand, specifically demands receivership in cases in which the violations are habitual or substantial and does not require a determination that the situation is threatening to the residents or that the facility is in danger of closing. This last approach supports the use of statutory nursing home receivership to upgrade substandard homes, thereby making it possible for a home to be rehabilitated before it is beyond repair.

C. *Powers*

Although the dual goals of the receivership—the protection of the health and safety of the residents and the conservation of the property of the owner—can be stated in one sentence, doing so does not make the essentially competing interests compatible. The protection of the health and safety of the residents in a substandard facility will always require additional expenditures unless the threat to the health and safety of the residents is from patient abuse instead of facility deterioration.

The irreconcilable conflict presented by the goals of receivership is implied within the statutes and is illustrated by the limits on the power of the receiver to spend money. Limits on the receiver's power are most frequently manifested in provisions for court supervision of expenditures over a certain amount. The conflict within the statutory receivership is even more strained as the goal of the receivership expands to home rehabilitation in situations in which the violations do not immediately threaten the health and safety of the residents but do seriously affect their well-being.

In the context of the frail nursing home resident and the shortage of available beds, it is crucial that steps be taken to preserve the facility whenever possible. Because of the significant difficulties associated with facility closings, the statutes should tip the balance toward improving the facility. This weighing is justifiable even against the property interest of the owner of a substandard facility. The cost of operating a facility in compliance with standards, as opposed to operating in violation of standards, is a cost of doing business imposed by law. The imposed standards represent neither a discretionary use of funds by the owner nor a reallocation of "profits." The cost of rehabilitating a facility, therefore, should not be a violation of the traditional duty of a receiver to conserve the assets entrusted to him by the court.

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34. The Missouri provision for receivership in cases of "emergency" may present an opportunity for a broader invocation of the receivership depending on the interpretation placed upon the term by the courts and on the circumstances of the facility. Due to the extraordinary nature of the receivership, the courts are likely to apply the standard conservatively.

The powers of the receiver appointed in a traditional equitable receivership are limited to those granted by the court.[35] The receiver's powers relate to the purpose of the equitable receivership; that is, the receiver, mindful of his temporary status and his primary charge to secure and preserve the assets in dispute, ordinarily does not undertake any significant alteration of the assets even if the alternatives may be considered an improvement of the property. The concern associated with the receiver's temporary status carries over into the limitations placed by statute upon the powers of the nursing home receiver. The Missouri statute specifically states that "[t]he receiver shall take such action as is reasonably necessary to protect and conserve the assets or property of which the receiver takes possession . . . ."[36]

All four statutes attempt to design the receivership so that it does not effect a "taking" of property without compensation. Three statutes specifically provide for an accounting at the end of the receivership. After the accounting, any excess of receipts over expenditures goes to the owner of the facility.[37] Minnesota and New York require the payment of a fair rental fee to the owners during the term of the receivership.[38] The New York statute explicitly states that "[n]either the receiver nor the department shall engage in any activity that constitutes confiscation of property without the payment of fair compensation."[39]

The primary purpose of the statutory receivership, however, is the protection of the health and safety of the residents. Each of the state statutes considered provides the receiver with the specific powers necessary to effect the primary purpose.[40] The New Jersey and Missouri statutes specifically state that the receiver shall have the power to "do all acts necessary or appropriate to conserve the property and promote the health, safety or care of the residents of the facility."[41]

New Jersey allocates the broadest powers to the receiver in accordance with the specific purpose of improving habitually substandard facilities.[42] Among the specific duties and powers listed in the New Jersey statute is the power of the receiver to hire any consultants or to

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35. Chicago Deposit Vault Co. v. McNulta, 153 U.S. 554, 561 (1893).

36. MO. REV. STAT. § 198.112(4) (Supp. 1980).

37. MO. REV. STAT. § 198.132 (Supp. 1980); N.J. STAT. ANN. § 26:2H-44 (West Supp. 1980); N.Y. PUB. HEALTH LAW § 2810(2)(e)(ii) (McKinney 1977).

38. MINN. STAT. ANN. § 144A.15(2) (West Supp. 1981); N.Y. PUB. HEALTH LAW § 2810(2)(b) (McKinney 1977).

39. N.Y. PUB. HEALTH LAW § 2810(2)(c) (McKinney 1977).

40. N.Y. PUB. HEALTH LAW § 2810(2)(c) (McKinney 1977); MINN. STAT. ANN. § 144A.15(3) (West Supp. 1981); MO. REV. STAT. § 198.112(13) (Supp. 1980).

41. MO. REV. STAT. § 198.112(9) (Supp. 1980); N.J. STAT. ANN. § 26:2H-41(c)(6) (West Supp. 1980).

42. N.J. STAT. ANN. § 26:2H-42(c)(1) (West Supp. 1980).

undertake any studies of the home deemed appropriate. The ability to pay for expert assistance, as a necessary expense of the receivership, greatly enhances the ability of the receiver to plan for the post-receivership life of the facility. The provision authorizing the receiver to "make *any* repairs, improvements or expenditures to eliminate the conditions specified in the complaint,"[43] which may include habitual though not dangerous violations of standards, greatly expands the receiver's powers in New Jersey.

Again, the Missouri Act, although less expansive, most closely approaches the breadth of the New Jersey provisions. Under the Missouri statute, upgrading the facility is a primary duty of the receiver, who is authorized to transfer the residents "if upgrading is not possible."[44] In Missouri, the receiver's power to upgrade the facility is limited only by the provision that expenditures over 3,000 dollars or over an amount set by the court in the appointment, must be approved by the court.[45] This limitation may discourage the receiver from more extensive repairs because of the inconvenience and expense of petitioning for court approval, but it is consistent with the temporary nature of the receivership and the goal of preserving the assets of the owner. It is a small obstacle compared to the limitations in the Minnesota and New York statutes.

Both Minnesota and New York, in identical language, provide that the receiver "may correct or eliminate those deficiencies in the facility which seriously endanger the health or safety of the residents unless the correction or elimination of deficiencies involves major alterations in the physical structure of the nursing home."[46] This is a twofold limitation. Only dangerous deficiencies may be corrected and, even when dangerous, only those changes that would not involve major alterations to the physical structure may be carried out. The latter restraint may be justifiable in light of the traditional goal of the receivership to preserve, and not alter or improve the property, the temporary status of the receiver, and the uncertain future of the facility. In a receivership established to protect the health and safety of the residents, however, the limitation is a self-contradiction.

This limitation highlights the fact that the integration of the traditional equitable receivership is not consistent with the requirements of a public safety receivership. There are degrees of danger, and some circumstances will require the immediate transfer of residents and the use of measures to avoid the adverse effects of transfer trauma. Nevertheless, the New York and Minnesota provisions do not require that transfer trauma be avoided at all costs. The

43. N.J. STAT. ANN. § 26:2H-42(c)(2) (West Supp. 1980) (emphasis added).
44. MO. REV. STAT. § 198.112(13) (Supp. 1980).
45. MO. REV. STAT. § 198.112(3) (Supp. 1980).
46. MINN. STAT. ANN. § 144A.15(3) (West Supp. 1981); N.Y. PUB. HEALTH LAW § 2810(2)(c) (McKinney 1977).

preceding limitation may appear reasonable. Nevertheless, if the conclusion is drawn from the statute without an assessment of the individual situation, including a judgment as to the likelihood of continued operation of the facility, the limitation is excessively conservative.

The implication of the limitation that only dangerous deficiences may be corrected is an unnecessary and unjustifiable limitation on the ability of the receiver to bring the facility into compliance. If the purpose of the provision is to preserve the assets of the owner, it is redundant in the face of the prohibition of major alterations and the ability of the court to supervise major expenditures. The owner's assets are not misused when they are directed toward bringing a facility into compliance with the standards of care prescribed by the law for owners and operators of nursing homes. A liberal interpretation of the statute may avoid the broad reach of the limitation by finding that the provision regulates only physical deficiencies, or that conditions not generally regarded as dangerous are dangerous in the context of the frail nursing home resident.

D. *Summary*

In examining the provisions of the four state nursing home receivership statutes one may identify the following three goals: (1) protection of the health and safety of the residents; (2) conservation of the property of the owner; and (3) rehabilitation of the facility in preparation for its continued existence. The first two goals are essential to the concept of the statutory receivership. The third goal, however, requires a more expansive view of the scope of the statutory receivership as a tool of nursing home reform. Bringing the facility into compliance with standards is consistent with the protection of the health and safety of the resident and conservation of the owner's property. Furthermore, if the statutory receivership is to avoid the faults of other enforcement mechanisms, the extent to which a receivership facilitates the rehabilitation of the facility and helps to ensure the facility's operation within statutory guidelines is the true measure of success.

In order to accomplish this goal, the ability to petition for a receivership should be granted to the resident and his family or guardian, as is permitted in both Missouri and New Jersey. As discussed above, the resident and his family suffer direct injury from violations of most standards. The potential for harassment or frivolous suits is not present because of the residents' real or imagined fear of retaliation. The provision in the New Jersey statute mandating that the owner be informed of violations and be given a reasonable opportunity to remedy them before a receivership is sought should be incorporated into receivership statutes to prevent unfair suits.

The grounds supporting a receivership under the New Jersey statute are those most directly suited to accomplishing the goal of rehabilitation. Because there is a danger that the courts would not appoint receivers under vague standards, a specific list of standards, as provided in the Missouri statute, would be a desirable supplement to the more general guidelines.

The powers granted to the receiver in each of the statutes are broad enough to support some activities leading to the rehabilitation of the facility. The powers of the statutory receiver are defined not only by the statute but, as in equitable receivership, by the court. Petitioners, therefore, should encourage the courts to broaden the receivers' scope of powers in appropriate cases. A receiver skilled in nursing home administration should be given broad latitude to improve the home provided the facility is not irredeemably substandard, there is a great need for a nursing home in the geographic area, and the potential for the eventual continuation of the home is strong.

As in equitable receiverships, the court retains supervisory power over the receiver. In the statutory receiverships, some supervision is mandated by the statute while overall supervision is required by the residual equitable power of the court. To the extent that courts may be reluctant to use the receivership because of the supervision required, the degree of supervision mandated becomes important. Furthermore, potential receivers may be reluctant to accept receivership appointments that may involve extensive court appearances. Finally, receivers may be hampered by the need for court permission before making expenditures. Again, the need to protect the property of the owner must be weighed in the balance.

The structure of the new statutory receivership provisions goes far in creating the potential for successful enforcement of nursing home standards while providing a workable alternative to the tragic choice of closing a substandard home. The statutory nursing home receivership is one of the most promising tools of nursing home reform. As might be expected, however, the statutes are not the only determinants of success. If the receivership is not to go the way of other highly touted nursing home reforms now judged to be failures,[47] it must be used in a creative and well-planned manner. The success of the promising receivership legislation will depend upon

47. When Governor James T. Blair signed Missouri's new nursing home law in 1957, he announced that this "was a great opportunity to help older citizens in Missouri who have found it necessary to live in these nursing homes. . . . All Missourians should be grateful to the legislature for this fine forward step." In 1978, the Director of the Division of Health in Missouri testified: "I do not believe that it will be possible for Missouri to close the bad homes or to deal more effectively with the marginal homes unless we have some different kind of legislation than we have at this time." STATE HEALTH CARE COMM., REPORT ON NURSING AND BOARDING HOME LICENSING IN MISSOURI, 78th Gen. Assembly, 2d Sess. 1 (1978).

creative and well-planned implementation on the part of the legislatures and effective enforcement by the courts.

III. THE VILLAGE NURSING HOME: THE FINE DETAIL OF REFORM

This section presents a detailed case study of the successful use of a receivership.[48] The identification of resources and actions which are crucial to success develops a model for effective implementation of nursing home laws.

The Village Nursing Home is a skilled nursing facility[49] located at 607 Hudson Street in the Greenwich Village area of Manhattan. It is the only skilled nursing facility in the area bounded by 59th Street and the Battery and Fifth Avenue and the Hudson River. Many nursing homes in Manhattan, as in other central city areas, have closed or have moved to the suburbs, creating a shortage of available local beds.

The building in which the Village Nursing Home is located was erected in 1902 and was converted into a nursing home in 1958. At the time of conversion, the facility was in full compliance with the then existing nursing home standards. As standards gradually became more demanding, the Village Nursing Home continued to operate,

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48. All documents, newspaper articles, and records of interviews are in the possession of the author. She may be reached at the St. Louis University School of Law, 3700 Lindell Blvd., St. Louis, MO 63108.

49. The term "skilled nursing facility" means (except for purposes of subsection (a)(2) of this section) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (l) of this section) with one or more hospitals having agreements in effect under section 1395cc of this title and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(4)(A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

(5) maintains clinical records on all patients;

(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals . . . .

42 U.S.C. § 1395x (j)(1)-(7) (1976).

but it had to acquire waivers of the new requirements.[50] On August 8, 1975, the State Health Department informed the operators of the Home that under the current regulations, the facility would have to reduce its population by more than a third and, further, that extensive structural renovations would be required for continued operation.

These two violations were not the only problems with the home. In addition to overcrowding, the absence of curtains between beds and doors in bathrooms eliminated privacy for residents. Paint was peeling off the walls, the building reeked with stale urine, and the residents complained of cold food and improper diets. Moreover, frequent transfers of the home's mortgage presented the possibility of fraud.[51]

After the Health Department notified the operators of the home on August 8, 1975, that they would be required to reduce the population and renovate the building, the operators applied for an increase in their per diem patient reimbursement rate from Medicaid on the ground that they were unable to make the required changes without the increase. On August 18 the request was denied. Families of some patients unsuccessfully attempted to dissuade the Health Department from its apparent plan to close the home. Some patients were transferred immediately. On August 28 Dr. Philip Brickner, director of medical services, who had been provided to the home by St. Vincent's Hospital,[52] wrote a letter to New York State Representative William Passanante detailing the medical danger of precipitous transfer of elderly nursing home patients. On September 3 the operators informed the Department, without submitting a transfer plan, that they intended to close the home within thirty days.

The action by the Health Department against the substandard facility came during a heyday of nursing home law reform in New York. The media coverage of the nursing home issue continued after enactment of the laws. Even after the enactment of the new law, a reform mentality prevailed during which the New York State Depart-

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50. The waivers given to the Village Nursing Home by the Department of Public Health applied primarily to structural deficiencies that were not the result of an intent to violate the standard, but rather were structural characteristics which met standards when the building was erected and later converted to a nursing home, but which became unacceptable as the standards became more demanding.

51. One method used to inflate the reimbursement rate from Medicaid was to transfer or sell the mortgage on the nursing home building or land at steadily increasing prices and thereby increase the reimbursement level. As the reimbursement rate is currently limited to the fair market value of the building, this method is no longer available.

52. The operators of the Village Nursing Home contracted with St. Vincent's Hospital for medical services, including doctors' visits to the home and hospitalization.

ment of Health, the legislators, and the general public measured success in terms of swift and strict enforcement. Delay, which had been identified as a cause for the failure of previous standards, was not to be tolerated.[53]

Despite the substandard and potentially life-threatening conditions in the facility[54] and the presumption in favor of strict enforcement of the standards, the community blocked the closing of the home because of the possibility of death due to transfer trauma and the need for a nursing home in Greenwich Village. Although the structural defects made the facility a potential inferno, the imminent transfer of unprepared residents had a far greater probability of causing many to die. The proven incidence of increased rates of death after the unexpected transfer of elderly patients from skilled nursing facilities has received the label "transfer trauma."[55]

The decision to oppose the closing of the Village Nursing Home was supportable in the face of transfer trauma. In fact, because of the crisis situation, opposition by the Village community to the closing of the home and transfer of residents was stronger than the support that had been demonstrated for rehabilitation and continued operation of the home.

The importance of maintaining a *local* nursing home also played a significant role in triggering opposition to the closing of the home. The patients of the Village Nursing Home were primarily Greenwich Village residents. Those who had retained some degree of mobility were able to visit friends and familiar places in the community. Because the majority of nursing home patients had no close families,[56] continuing relationships with old friends, who might be

53. Nursing home law reform in New York followed the now familiar pattern: newspaper exposés of conditions in nursing homes are followed by a state investigation (with continuing media coverage), proposed legislation, and a tragic case illustrating the danger of substandard facilities or inadequate protective standards that culminates in swift passage of the law. Missouri followed the same pattern twice in the history of its regulation of nursing homes. After a facility burned to the ground in Warrenton, Missouri in 1957, Missouri passed its first nursing home law. MO. REV. STAT. § 198.011 (1957). *See* State ex rel. Eagleton v. Patrick, 370 S.W.2d (Mo. 1963) (providing statutory history and citing the Warrenton incident as the impetus for the legislation). Again, in 1979 a fatal fire in a Farmington boarding home provided the final thrust for passage of the Missouri Omnibus Nursing Home Act, MO. REV. STAT. §§ 198.003 to .186 (1980 Supp.).

54. The structural deficiencies affecting fire safety included staircases that could not accommodate wheelchairs and elevators that were too small for evacuation.

55. Studies conducted in the late 1960's found that sudden, involuntary transfer of frail elderly nursing home residents could increase their death rates significantly. *See* note 3 *supra*.

56. SUBCOMM. ON LONG-TERM CARE OF THE SENATE SPECIAL COMM. ON AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, S. REP. NO. 93-1420, 93d Cong., 2d Sess. 16 (1974).

unable to visit a distant facility, was the residents' only contact with their former life. As a local facility, Village Nursing Home was able to encourage frequent and regular volunteer activity from outsiders. The people of Greenwich Village identified the Village Nursing Home as *their* nursing home.

The following case study of the Village Nursing Home describes, isolates, and analyzes the elements of successful community action in support of quality nursing home care.[57]

A. *Stage One*

Over the Labor Day weekend, after the operators had announced that they would close the home, families of some patients contacted Community Planning Board #2 (CPB), a local advisory governing body of Greenwich Village. Lenore Cahn, a member of the Social Action Committee of CPB, took charge.

Cahn led the opposition to the transfer of Village Nursing Home residents in January 1974. At that time, the State Health Department transferred patients from the Village Nursing Home to health-related facilities outside Manhattan. The action was taken after the utilization review of each case had indicated that the individual residents required less medically intensive care.[58] Litigation in other localities in opposition to nursing home transfers often had been unsuccessful. When utilization review transfers began at the Village Nursing Home litigation was not the strategy chosen. Rather, Cahn and United States Representative Edward Koch led the opposition to the transfers by initiating community action. They based their opposition on both humane and economical considerations. Cahn and Koch argued that trauma associated with nursing home transfers can kill, and that money would not be saved because the Village Nursing Home, with one of the lowest rates of reimbursement in New York State, was less costly to operate than the health-related facilities to which the patients would be transferred. The state halted the transfers from the Village Nursing Home.

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57. Berman, *The Nursing Home Morass: Likelihood of Extrication and Reform*, 17 ARIZ. L. REV. 357, 371 (1975); Malloy and Meyer, *Nursing Home Regulation in New Jersey: An Outline of Proposals for Reform*, 1 SETON HALL LEGIS. J. 20 (1976). Both articles emphasize the potential of community action as an enforcement tool.

58. Both Medicare, 42 U.S.C. § 1395y (a) (1976 & Supp. III 1979), and Medicaid, 42 U.S.C. § 1396a (a)(30) (1976), mandate that the nursing home patient not receive a higher level of care, in terms of the medical intensity of the care, than is required. Each case undergoes a periodic utilization review through which a committee examines the patient's history and prognosis and determines whether the patient requires the current level of care. If the patient does not need the level of care he is then receiving he must be transferred from the facility to another, less medically intensive, facility.

The results of this effort laid the groundwork for a later, more demanding undertaking and brought the issue of transfer trauma before the Greenwich Village community. Elected officials were acquainted with both the issues and the participants. The community, in fact, demonstrated its awareness of CPB through the numerous calls it made to CPB during the Labor Day weekend in 1975 when the crisis arose.

In response to these urgent calls, Cahn, on behalf of CPB, contacted James Janewski and Father Robert V. Lott, cochairmen of Caring Community, Inc., a nonprofit organization of churches, synogogues, and social service groups that served the elderly through several small, independent programs in Greenwich Village.

At the same time, Ann Wyatt, a social worker/gerontologist and resident of Greenwich Village, who had been volunteering at the home, was notified of the problem by a personal friend in the New York State Department of Social Services. Wyatt contacted Andrew Zweben and Philip Gassel, attorneys with Legal Services for the Elderly Poor, a Legal Services Corporation back-up center in New York City.

The local press covered the developments immediately. A well attended community meeting was held on September 10. At this meeting, the Ad Hoc Committee to Save the Village Nursing Home (the Committee) was formed. The executive group of the Committee, including Cahn, Lott, and Wyatt, became the unified leadership of the effort.

Zweben and Gassel immediately initiated legal action with several home residents as plaintiffs. On September 11 the state court issued a temporary restraining order stopping transfer of the patients and set a hearing for September 12. On September 12 the hearing was postponed, but the temporary restraining order stood. On September 18 the operator agreed not to transfer patients for at least three weeks and court action was again postponed.

Community-wide action between September 11 and early November consisted of community meetings, petitions, letters, press coverage, and meetings between the Committee and both the local elected officials and the State Health Department. The most significant action occurred on September 14 when there was a possibility that the entire staff of the home would seek more secure employment elsewhere. An en masse resignation was avoided by the action taken in following days.

At this stage, the Committee considered St. Vincent's Hospital, the only hospital in the immediate area of the home, as a possible permanent operator of the home. On September 14 the Committee sent a mailgram to the Health Department asking for an expedited procedure enabling St. Vincent's to become the permanent operator.

At a September 18 meeting the Health Department indicated that the hospital would be an acceptable operator. In the first week of October, St. Vincent's expressed interest in operating the home. The State Health Department estimated that it would take three weeks to reach a final settlement with the hospital. On October 23 the landlord of the building in which the home was located informed representatives of the Health Department, the Committee, and the hospital that the selling price for the building would be more than the Medicaid reimbursement.

B. *Stage Two—The Receivership*

On September 11, only ten days after the effective date of New York's nursing home law,[59] a State Health Department official raised the possibility of a statutory nursing home receivership for the Village Nursing Home. Representative Koch sent a letter to the Health Department the next day emphasizing the importance of the Village Nursing Home as a community nursing home and asking that implementation of the receivership law be considered. Nevertheless, since St. Vincent's Hospital was seriously considering becoming the permanent operator of the facility, the Committee took no action toward receivership.

On October 29, after an October 23 meeting with the hospital and the home's landlord, the State Health Department, in a letter to State Representative Manfred Ohrenstein, stated that "[s]ince the Village Nursing Home . . . matter is our first attempt to implement the law [on receivership] we are gaining experience as we proceed and are trying to resolve problems and overcome obstacles."[60]

On Thanksgiving Eve, *The New York Times* reported that the owner of the Village Nursing Home had notified the State Health Department that they would close the home the following Wednesday night "stranding 267 patients and leaving the lower west side without a single nursing home."[61] Understandably, panic and confusion arose among the Committee, the residents, and residents' families. The owner later denied the report.

The crisis motivated the Health Department to make an announcement which emphasized that the owner could not close the home without Department approval. The Department commented

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59. N.Y. PUB. HEALTH LAW § 2810 (McKinney 1977).

60. The Department at that time was apparently attempting to lead the operators of the Village Nursing Home to voluntary receivership rather than run the risk of a long battle with the operators who would oppose the voluntary receivership. At that time, the statute required that in cases of involuntary receiverships, the owner had the right to exhaust all administrative and judicial appeals before the imposition of the receivership. This provision has been repealed. *See* note 70 *infra*.

61. N.Y. Times, Nov. 29, 1975, at 46, col. 1.

that its impression was that St. Vincent's Hospital was no longer interested in permanent operation of the home and that the Department would seek a court-appointed receiver on December 1. In early December it became apparent that St. Vincent's Hospital would not become the operator. At the December 2 meeting of the Health Department, the Department reiterated to the operators of the home, the hospital, the Committee, and the elected officials that if necessary, it would seek a court-appointed receiver.

The focus then shifted entirely to the receivership, with St. Vincent's Hospital briefly attracting the most attention as a possible receiver. On December 25, 1975, *The Villager*, a neighborhood newspaper, reported that the hospital was unwilling to become a receiver.[62] On January 12, 1976, the State Health Department stated that they had asked the Hospital to consider becoming the receiver but St. Vincent's refused, believing that the receiver under the receivership law would become the permanent operator of the home.

No one was certain what the responsibilities and obligations of a receiver would be. In fact, very little was known about the implementation of the nursing home receivership provision in a particular case, even though it had been drafted with some specificity. Lott, co-chairman of Caring Community, Inc. and a member of the Committee, believed that the receiver had to be someone willing to work closely with the community.

The general uncertainty surrounding the receivership became more evident in several local newspaper reports. On December 4, 1975, *The Villager* reported that the receiver would be a state official or someone appointed by St. Vincent's Hospital.[63] On January 29, 1976, *The Villager* reported that the receiver would be a lawyer who would have temporary responsibility for managing the home.[64] On February 2 *The Villager* reported that the receiver would become the eventual operator of the home.[65] Meg Reed, legislative assistant to State Representative Ohrenstein, stated that the "receiver should be someone with no prior connection to nursing homes, and who has the confidence of the community."[66]

The responsibility for finding a willing receiver fell upon the State Health Department. The Committee was totally ineffective at this stage. The daily management of a nursing facility seemed beyond the ability of anyone the Committee knew. The Committee had no contact with professional health administrators other than St. Vincent's Hospital, which apparently was not interested in becoming the

62. The Villager, Dec. 25, 1975, at 1, col. 1.
63. The Villager, Dec. 4, 1975, at 1, col. 1.
64. The Villager, Jan. 29, 1976, at 1, col. 3.
65. The Villager, Feb. 2, 1976, at 1, col. 1.
66. *Id.*

receiver for the facility. The idea of hiring a temporary administrator had not yet been developed.

Finally, Jewish Home and Hospital for Aged (JHHA), a non-profit corporation which operated several high-quality skilled nursing facilities in New York, agreed to become the receiver for the statutory period of eighteen months.[67] Mitch Waife, of JHHA, had been a member of the Moreland Act Commission, established by Governor Hugh Carey in response to earlier nursing home scandals. The Commission had studied the problems of nursing homes and had developed proposals for a reformed state nursing home law. One of the Commission's proposals included the receivership law.[68] JHHA emphasized from the beginning that it would under no circumstances become the permanent operator of the home.

The New York statute provided for both voluntary and involuntary receivership.[69] It appeared, however, that the operators would oppose a receivership and appeal the appointment of a receiver by a lower state court, thus delaying resolution of the matter.[70] On January 14, 1976, the State Health Department, in accordance with a provision for civil fines, assessed a fine of 1,000 dollars a day against the Village Nursing Home operator.[71] On January 28, 1976, the operator did petition the court for a voluntary receivership.[72] The formal appointment of the receiver for a period of eighteen months was not made until March 31, 1976, and took effect on April 1, 1976.[73]

JHHA met with community representatives and established a liaison committee, which included Lott, Cahn, and Wyatt. John Issowits, a professional health facility administrator, was assigned to

67. N.Y. PUB. HEALTH LAW § 2810(2)(a) (McKinney 1977).

68. The Commission eventually published its recommendations in a multi-volume report. One of its recommendations was the statutory receivership.

69. N.Y. PUB. HEALTH LAW § 2810(1), (2) (McKinney 1977).

70. The original version of N.Y. PUB. HEALTH LAW § 2810(2) (McKinney Supp. 1976) in effect in 1976 that governed involuntary receiverships read: "Such application for receivership shall contain proof . . . that all judicial appeals available to the owner of the facility have been completed, or the time for taking such appeals has expired." The involuntary receivership, therefore, was limited in its effectiveness as a tool of rapid enforcement. To provide the operator with the opportunity to exhaust all available appeals before the appointment of the receiver is contrary to the traditional operation of a receivership, which has as its purpose the preservation of assets pending resolution of disputes through litigation. When the legislature amended section 2810(2) in 1977, it deleted this requirement.

71. N.Y. PUB. HEALTH LAW § 2810(1) (McKinney 1977).

72. Unreported Order of the Supreme Court of the State of New York at 27 (Hyman Korn, Justice), March 31, 1976, Index No. 1022/1976.

73. The voluntary receivership under N.Y. PUB. HEALTH LAW § 2810(1) (McKinney 1977) had no statutorily mandated termination date; rather, the receivership was to terminate on a date agreed upon by the parties. At the end of the agreed upon 18 month period, the receivership for the Village Nursing Home was extended for an additional six months.

carry on the day-to-day operation of the home; Medicaid payments to the home reimbursed JHHA for Issowits' salary. The rest of the staff remained relatively unchanged and St. Vincent's Hospital continued to provide medical care under contract. Although Issowits' power to make significant improvements was limited by the receivership statute,[74] he improved the home wherever possible and supported the rehabilitation and continued operation of the home. The population of the home decreased steadily through attrition and transfers were stopped. Cahn reported to CPB that "we can be assured that with this receivership our primary objection [sic] has been accomplished: that of preventing any precipitous inhuman transfer of patients. If at a future date, transfers are necessary they will be carried out with care and concern for each individual."[75]

C. *Stage Three*

Cahn reported to CPB on March 18 that "[o]ur next goal is to have a permanent quality nursing home located in this community. We hope that St. Vincent's Hospital will find it financially feasible to move ahead on this."[76] The Committee had complete responsibility for finding a permanent operator. St. Vincent's fully investigated the possibility of taking over the facility but was never enthusiastic.

On April 9, 1976, *The New York Times*[77] reported that New York had decided to reduce Medicaid reimbursement for services rendered in nursing homes to the lower federal levels. Nonprofit homes, as the Village Nursing Home would become if operated by St. Vincent's, would be most affected because they were already committed to supplying services to their residents at the higher state reimbursement level.

St. Vincent's commissioned a confidential feasibility study by Coopers & Lybrand. The firm sent a questionnaire to the medical staff of the hospital concerning projected use of the home in the area. The result of the study was positive. St. Vincent's also investigated the cost of renovating the building to comply with standards and concluded that renovation would be financially impossible. This conclusion, however, did not foreclose the hospital's owning the home since it was planning to build or acquire a new plant.

The Planning Committee of the Board of Trustees of St. Vincent's hospital had primary responsibility for investigating the

74. N.Y. PUB. HEALTH LAW § 2810(2)(c) (McKinney 1977). The statute prohibited major alterations and limited expenditures. Unless the receiver followed a bidding procedure, expenditures for repairs, improvements, and supplies were limited to $500.

75. Oral report delivered to Community Planning Board #2 on March 18, 1976.

76. *Id.*

77. N.Y. Times, April 9, 1976, at 20, col. 4.

feasibility of having the hospital permanently operate the home. The Board considered the issue on June 9, 1976, but reached no decision. As a result, no action was taken until October because no meetings were held in Greenwich Village during the summer months.

On October 20, 1976, the Planning Committee passed a resolution recommending that St. Vincent's not undertake permanent operation of the home because of the projected low level of Medicaid reimbursement. The entire Board of Trustees accepted the resolution at its next meeting on November 17, 1976, and then informed the Committee.

The Committee had not investigated any other possible operators during the period in which St. Vincent's was considering the matter. Members of the Committee later indicated that they had felt paralyzed because St. Vincent's appeared to be the only possibility and because a new building would be needed. At this point, seven months of the eighteen-month receivership had passed.

In late November 1976, the federal Department of Health, Education, and Welfare (HEW) sent investigators to the Village Nursing Home. Under the Medicare/Medicaid system, the federal Department usually relied on the State Health Department to enforce standards. HEW was aware, however that nothing had been done since August 1975 to correct the structural defects in the home. Consequently, HEW was in a position in which it could let the Medicare contract expire, and thereby end the home's federal funding. Under the terms of the receivership, the state would then have to make up the difference between income and expenditures for the period of the receivership, and the home would have to close at the end of the receivership period. Lott and Wyatt met with a representative of HEW to discuss the problem. The representative asked whether there was community involvement in the home or whether the problem was just a political issue.

During the summer of 1976, when progress on finding an operator for the home was at a standstill, Wyatt turned her energies toward the residents of the home and developed a newsletter and promoted regular visitation by community members and students. Up to that point, community involvement with the home had been minimal.

Wyatt's work during the summer of 1976 was used to convince HEW that there was community involvement and a community commitment to keeping the home open and bringing it into compliance with the regulations. At that point, the representative from HEW indicated the building could be renovated at a reasonable cost.[78]

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78. The Village Nursing Home had a long history of noncompliance with both federal and state standards. The Department of Health and Human Services (HHS) relies primarily on state enforcement of both federal and state standards.

According to Wyatt, Lott, and Cahn, this possibility changed the scope of the problem. Lott suggested that Caring Community, Inc. would be a proper choice for a permanent operator. Not only did that organization serve the elderly, but it had developed recognition among the community. Wyatt wrote and presented a proposal to Caring Community, Inc. in which she urged that it examine the prospects. A panel of experts was assembled that included lawyers, fundraisers, social work students, and Wyatt. As Cahn noted, the consultants became stronger than the Board, due to their aura of expertise. The other major participants, however, remained the same, with Cahn, Waytt, Lott, and Issowits being the most significant members of the group.

Issowits advised Caring Community, Inc. on the financial aspects of administering a nursing home. He persuaded Caring Community to contract out the daily administration of the home to JHHA, just as the home had previously contracted out provision of medical service to St. Vincent's Hospital. This would allow Issowits to remain at the home and would relieve Caring Community of responsibility for performing functions beyond their expertise. Caring Community applied for approval as the permanent operator for the home and negotiated for state monies to pay for renovation and either purchase or rental of the building. The bureaucracy involved at this stage was complex.[79]

Usually, only in situations in which the state enforcement appears ineffective does HHS move to decertify a facility from participating in Medicare and Medicaid. The Village Nursing Home apparently was this type of case. Even after the community action in 1975 and 1976, there had been very little progress in improving the facility. The community commitment itself did not, at first glance, support a decision to allow the home to operate a seriously deficient facility because the community group was apparently a loose amalgam of persons who had little expertise in nursing home administration and no power to upgrade conditions at the home. The Department of Health, Education, and Welfare (HHS's predecessor) feared that community participation would end after it succeeded in keeping the home open and that it would never emerge into a constructive force in the rehabilitation of the facility. Apparently, HEW believed that the coalition would dissipate over time, as community groups often do. The decision to withhold information on the possible rehabilitation of the facility was justified in light of the real possibility that the community's vociferous opposition to the home's closing would continue but that the groups involved would be unable to rehabilitate the facility. The threat of decertification was effective in pushing the coalition toward making real progress in negotiating for the purchase of the facility, applying for a state license to operate the home, and raising the $275,000 purchase price. Although Lott and Wyatt and other community members saw HEW as an antagonist at the time, HEW's effective decertification threats prodded the group to action at several points in 1976.

79. A meeting held in March 1977 to explain the requirements for applying for approval as permanent operators of the facility and for negotiating state reimbursement was attended by 18 people. The State Department of Health was represented by two attorneys, the Medical Facility Planner, a representative of the Establishment Unit, a representative of the Reimbursement Unit, the Regional

Caring Community's application for approval as operator floundered, as the organization attempted to negotiate the purchase of the building as well as a reimbursement rate. Although Legal Services of the Elderly Poor had assisted the community coalition in stopping the transfers in September 1975 and had assisted briefly thereafter, the organization was not designed to deliver legal services for clients but rather was designed to develop back-up services for local legal aid offices around the country. It, therefore, had discontinued direct services early in 1976. Caring Community had no money to hire a lawyer, so it needed *pro bono* legal counsel. In April 1977, after a three-month search, the Committee retained, through the efforts of New York Lawyers for the Public Interest, lawyers from two prestigious Wall Street law firms on a *pro bono* basis.[80]

The attorneys for Caring Community negotiated a purchase agreement with the owner of the building. The purchase price agreed upon exceeded the amount reimbursed by the state by 275,000 dollars. The state, however, agreed to reimburse Caring Community for the complete cost of rehabilitating the facility.

Caring Community began a massive fund-raising campaign. Wyatt applied for grants from several foundations with limited success; the largest grant totalled 3,000 dollars. Caring Community centered the fund-raising campaign almost entirely in the community surrounding the home. This approach provided both public education on the need for a nursing home and opportunities for community involvement in the home. Local volunteers prepared nearly 15,000 fund appeals. Community organizations throughout Greenwich Village raised money by holding summer street fairs, bake sales, and raffles. Small businesses in the area donated money and items for auction. A public relations employee at St. Vincent's Hospital donated her skills, as did a professional fund-raiser. The Village Nursing Home received coverage in the local Village newspapers and in the major New York newspapers and television news reports.

Office Representative, a representative of the Long-Term Care Unit and a Senior Sanitarian. The other persons attending included two representatives from HEW's Office of Long-Term Care, Mitch Waife and John Issowits for Jewish Home and Hospital, legal counsel and an architect for the landlord, a legal consultant for the Ad Hoc Committee and Cahn, Lott, and Wyatt.

80. The two law firms were Willkie, Farr & Gallagher and Winthrop, Stimson, Putnam & Roberts. The New York Lawyers for the Public Interest (NYLPI) is a nonprofit instrument established by several large law firms for the purpose of screening and assigning *pro bono* projects proposed by community groups to the law firm best suited to serve the needs of the group. This organization saves the law firms the time involved in screening requests and the political problems incurred in rejecting the proposals of community groups. The NYLPI was a relatively low-budget operation with a staff consisting, at that time, of one attorney, who sometimes rendered *pro bono* legal services himself, and a secretary.

Caring Community raised more than 275,000 dollars within approximately eight months. The number of volunteers increased, many of them coming from outside the few groups directly involved in the coalition. In fact, the current community Board of Directors for the home primarily consists of volunteers who came to the cause during the campaign.

The Community purchased the building and began to operate a separately incorporated community-owned nursing home. As Issowits suggested, Caring Community contracted out the medical care to St. Vincent's and the daily administration to JHHA. Caring Community established a Board to supervise the policy decisions in the home. Board members included persons affiliated with Caring Community and JHHA, as well as persons unaffiliated with either group.

As with many community boards, the Board sometimes is slow to act, inclined to frequent meetings, and subject to disagreement. As of now, the effectiveness of community ownership of Village Nursing Home cannot fully be assessed.[81] The Board has made several improvements in the home. The population has been kept at less than 200 residents, the level allowed by the standards. The Board has painted the lobby, it has hung curtains and doors, and it has begun more extensive structural renovations. There has been frequent and consistent involvement by volunteers, and the residents in the home have been encouraged to participate in community activities whenever possible. Caring Community has expanded, offering even more services to the elderly. The home, in effect, has shown the potential for continued improvement.

IV. ANALYSIS OF THE VILLAGE NURSING HOME EXPERIENCE: WHAT MADE IT WORK?

> Our ideas about institutionalizing the aged, psychotic, retarded, and infirm are based on a pattern of thought that we might call the Toilet Assumption—the notion that unwanted difficulties, unwanted complexities and obstacles will disappear if they are removed from our immediate field of vision.[82]

The successful community involvement in the Village Nursing Home is remarkable. To protect themselves from confronting the inadequacies of placing old people in nursing homes, civilians generally are conspicuously absent from nursing homes. There also appears to

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81. Caring Community, Inc. received a large two-year grant from the Department of Health, Education, and Welfare in 1978. The first part of the grant was designed to establish a model of community participation in the decisionmaking process in nursing homes. The second part funded the writing of a book describing and evaluating the effort of the community in the Village Nursing Home with a view toward developing a prototype.

82. SLATER, THE PURSUIT OF LONELINESS 15 (1976).

be a mystification about total institutions,[83] whether it is a nursing home, a prison, or a mental institution, that causes outsiders to fear entering the facility except during group action activities, such as holiday entertainment programs.

In many ways the sequence of events at the Village Nursing Home was typical of a community's response to the proposed closing of a nursing home. Before the community expressed concern about the utilization review transfers in 1974, there was only the sporadic, volunteer involvement, typical of nursing homes. Even after that successful action, community involvement returned to the previous low level. The reaction to the 1975 tranfers was, at first, individualistic. Families and friends of residents in the home tried in vain to deal with the bureaucracies involved. Finally, community action was undertaken when local citizens began monitoring the home's progress and demonstrating on its behalf.

Characteristically, community efforts, other than those that are highly organized or are joined to a stable structure, are often dispersed and ineffective. Reliance on volunteers and difficulties in communicating and translating complex issues into short-term goals contribute to the ineffectiveness of these groups. The situation in Greenwich Village, however, was different because of the community participants' prior experience in various aspects of the project and because of effective use of the media, political resources, and the legal system.

The coalition was unusual in that each member came to the group as a representative of organizations that could help the effort, including Caring Community, the Community Planning Board, a legislator's office and the hospital. Each organization was a recognizable, permanent part of the Greenwich Village community. Additionally, a network of individuals and organizations serving the elderly was in existence prior to the crisis. This network facilitated communication, education, organization, influence, and participation within the community. In fact, it is doubtful whether an effective, concerted effort could have been organized without this pre-existing network.

The media was clearly an essential force in the Village Nursing Home affair and was one of two "swing" groups whose participation significantly influenced the final result of the effort. The Health Department's location in Albany hindered its responsiveness to the

83. A "total institution" is a label used to describe a facility in which residents of the institution depend upon the facility for daily needs such as food, clothing, and health care. There is little opportunity for time outside the facility. Daily life tends to be scheduled by the facility, not the residents. Nursing homes fit the category neatly, especially considering the dependence described earlier in this article. *See* note 1 *supra*.

media's need for information and, as a result, the local office in New York City and the office in Albany often issued conflicting information. As is common with centralized bureaucracies, no individual, other than one at the highest level, was able to give any information or opinion without first having it examined and approved for consistency with bureaucratic policy.

State agencies often do not have the capacity for timely, specific, and persuasive answers to specific questions. Because the official bureaucracy is usually not intimately familiar with the neighborhood or the persons involved, it is often unable to develop the human interest story which attracts favorable media coverage.

The use of the media by the community coalition, on the other hand, was a model of effectiveness. The community coalition kept the neighborhood newspapers informed of its version of the course of events. It scheduled media events, such as interviews with residents of the home, and a visit by the First Lady. The task in this case was not to create public interest in the topic when there was none but rather to personalize the issue of nursing home reform and to break the stereotypes of nursing homes and nursing home residents.

The general public became aware of society's interest in nursing homes through the newspaper exposés and resultant legislation. The media image of nursing homes, however, reinforced the popular concept of nursing facilities as generally dismal and undesirable places, and the residents as helpless, abused individuals slumped in wheel chairs around the television or sitting in the lobby. The exposés and resultant legislation also created a reform mentality during which success was measured by swift and strict enforcement of the standards regardless of the advisability of the enforcement.

In the case of the Village Nursing Home, the community coalition persuaded the public that the imminent danger of transfer trauma outweighed the advantages of immediate enforcement of statutory standards. The coalition also was able to delay enforcement because of the need in the Greenwich Village area for a skilled nursing facility and because of the potential for rehabilitation of the home. The successful invocation of the receivership provision required that time be spent searching for an appropriate receiver, establishing the duties and liabilities of the receiver, and demonstrating the potential of the facility for continued operation once the receivership expired.

The politicians who had an influence on the decisions of the state administrative agencies could have supported either side in the dispute over the future of the home. Each had supported nursing home law reform. It would have been politically dangerous, therefore, for them to advocate an exception to the strict enforcement of the law against a substandard home. Village residents im-

mediately contacted the local politicians when the State Health Department threatened the home. This response did not occur through any unique or sophisticated political process; rather, the Committee used the politicians to its advantage by inviting them to meetings, by presenting them with discrete issues, and by requesting from them only well-defined assistance. In order to discourage undesirable requests before they became public, a legislative assistant to one of the politicians involved in the Village Nursing Home situation attended all the community meetings. The assistant also expertly coordinated relations with other politicians.

The Village Nursing Home effort was a legalistic battle involving legislation, implementation of legislation, litigation, and regulation. The community coalition sought legal assistance at the beginning of transfers. The intervention of Legal Services for the Elderly Poor bought time for the community coalition by securing the temporary restraining order against the transfers. Nevertheless, several transfers took place in the dead of night, even after the temporary restraining order. The surveillance of the home by community residents finally enforced the order. Although the court action was eventually effective in preventing transfers, it was ineffective in accomplishing the goal of developing both a legally enforceable requirement and a set of standards for preparing patients for transfer because the action ended with an agreement by the home to stop the transfers.

Legal Services for the Elderly Poor was not able to continue serving the Village Nursing Home coalition because it was primarily responsible for test case litigation.[84] After the initial successful legal action to halt the tranfers, the effort nearly failed because the community coalition for a time was unable to find *pro bono* legal counsel to help them during the receivership. *Pro bono* legal assistance to nonprofit community groups is difficult to secure for several reasons. The range of skills and substantive knowledge required by active community groups is often very broad. For example, the committee for the Village Nursing Home used legal counsel to negotiate and draft the contract for the purchase of the home, to negotiate the reimbursement rate from the state, to advise on the renovation of the home to meet standards, to negotiate and litigate the appointment of

84. Andrew Zweben, the attorney from Legal Services who brought the original suit for a temporary restraining order against the transfers, stated in an interview that he found working with the Committee, as with all community groups, time-consuming. He stated that working with the Committee required him to perform services that did not fit his self-concept of the lawyer's role. For example, he objected to time spent at meetings explaining the course of legal events to the members of the coalition and the community. He also disliked having to act as the "loudmouth" for the group in its relations with the bureaucrats and politicians. These services, to be sure, did not fit into the Legal Services for the Elderly Poor's role as a Legal Services Corporation back-up center for test case litigation.

Caring Community as receiver after the expiration of the initial receivership period of eighteen months, to incorporate the Village Nursing Home as a nonprofit corporation, and to speak at community meetings. The assistance of the attorneys at this stage was essential because of the complexities and the range of tasks associated with the project. The attorneys for the Village Nursing Home performed *pro bono* services for more than a year and they were called several times to speak at community meetings on the legal issues and courses of action taken by the Committee.

The advantage of this type of *pro bono* activity to the attorney is twofold. First, for firms primarily engaged in corporate or commercial matters, providing services to a community group often does not require learning areas of the law or legal skills which are totally unrelated to the usual practice of the firms. Newer associates in the firm can, with supervision, do much of the work and at the same time develop skills such as negotiation, client counseling, drafting, administrative practice, and incorporation. Further, services to a community group usually will not require time-consuming litigation but rather, will include the more predictable activities of negotiation, drafting, and practice before administrative agencies. Second, the impact of the *pro bono* activities can be large and visible. The two firms that served the Ad Hoc Committee to Save the Village Nursing Home can point with pride to the fruits of their labor.

Receivership was the single most effective legal device used during the Village Nursing Home effort. The operator of the home had the right to close the home. If that had occurred, there would have been no time to develop alternative placements for the home's patients. Receivership gave the community this needed time. In addition, receivership put the eventual operators into contact with professional administrators. Several problems, such as delays, were encountered during implementation of the receivership. The delays were due in part to this being the first use of a new statute. Other problems, such as the dearth of eligible receivers, are endemic to statutory nursing home receivership.

The primary problem with the implementation of a statutory receivership, as illustrated by the Village Nursing Home experience, is finding a receiver. The New York statute does not designate a particular receiver. It took over four months to persuade JHHA to become the receiver. One of JHHA's main concerns was whether it would be able to relinquish its obligations at the end of the receivership period, as it did not want to become the permanent operator of the facility. If a receiver has a strong position on this issue that position should be made clear at the beginning of the relationship. There is no guarantee that the receiver will be able to avoid permanent ownership. The Village Nursing Home experience, however, should encourage institutions to volunteer for a limited-time receivership.

JHHA was the ideal receiver in terms of the skills it brought to the task and also in terms of the pressure it exerted through its clear refusal to become the permanent operator. Any indication of willingness on the part of the receiver will usually result in its becoming the permanent operator of the facility. In the case of the Village Nursing Home, the eventual permanent operators learned from JHHA and inherited the foundation for a well-run facility.

Because of the difficulty in finding a willing receiver, the Department of Health, or similar administrative agencies, have been included as possible temporary receivers for nursing homes in several statutes providing for receiverships.[85] The designation of any state agency as receiver will harm the effectiveness of the provision by completely removing the leverage that JHHA had in refusing to become the permanent operator. Because of the political nature of such agencies, they will be more subject to pressure by the public and politicians to keep homes open than would private groups. In addition, the state agency will eventually become less willing to use the receivership than it would be initially because of an understandable unwillingness and inability to administer the daily needs of several facilities. The state agency receivership also would be more threatening because it would bring with it the spectre of the state's "taking over" the home. Finally, if the state agency became the receiver there would be little encouragement for the time-consuming but necessary task of developing broad-based community support for the retention of the facility.

The Village Nursing Home experience illustrates that community action is crucial if a receivership is to progress beyond the orderly shutdown of the facility. The "community coalition" was typical of most community coalitions. The coalition responded best to crises and deadlines, but, in the periods of calm, was unable to progress. The coalition was accountable to large groups of people and, therefore, meetings became a time-consuming way of life. Each member of the coalition was a volunteer and, as a result, demands of jobs and family limited the amount of time each could make available to the home.

Most members of the Committee had no particular technical skills themselves but were able to bring into the core of the decision-making body a group of volunteer experts, including lawyers, a fund-raiser, politicians, a public relations person, and a health facility administrator. The recognition of the need for expert assistance and the ability to get it at each step of the way was important. Every decision, application, and action, therefore, took a longer than normal time to accomplish. A coalition simply requires more time than a

85. N.Y. PUB. HEALTH LAW § 2810(2)(a) (McKinney 1977); MINN. STAT. ANN. § 144A.15(2) (West Supp. 1981); MO. REV. STAT. § 198.105 (Supp. 1980).

smaller operation to achieve its goals. If community action was the foundation for the success in redeeming the Village Nursing Home, the statutory receivership was clearly the keystone in that it provided time within which the community was able to develop and execute a plan for the facility's future.

Even more important than the breathing space provided by the statutory receivership is the extent to which the New York statute focuses on the termination of the receivership. If there is no plan for terminating the receivership it is likely to develop into a long-term mode of operation for the facility. Such an extended receivership is contrary to the intrinsic nature of a receivership. The design of a statutory receivership depends on its temporary nature. For example, a state health department usually does not have the resources to administer skilled nursing facilities for a long period of time. Further, the limits placed on the receiver's power by most state statutes do not allow for a significant upgrading of the facility during the receivership.

Within the statutes there are some devices favoring planned termination. All of the state statutes require that the receiver prepare the residents for the eventual closing of the home and provide for resident transfer to other facilities. In a case in which there is a great deal of public concern, as in the case of the Village Nursing Home, it may be politically impossible to close the home unless clear deadlines are set for the development of alternatives. In any case, if the receivership is to do more than safely close the facility and transfer the residents, the brunt of the planning for the termination of the receivership must be accomplished during the course of the receivership.

In the context of the Village Nursing Home, there were several factors contributing to the final resolution of the problem. First, the court order appointing the receiver set an eighteen month deadline for termination. Although this was eventually extended by six months, the deadline itself helped to speed up efforts to plan for the future in concrete ways. Second, if definite plans were not in effect at the time of the deadline, it was clear that the facility would close. The community, therefore, was aware of the seriousness of the deadline and, further, was able to keep up the pace of activity under the banner of "Save the Village Nursing Home." Last, the JHHA, as noted above, had made it clear that it would not become the permanent operator. This forced the community group, from the beginning, to look elsewhere for a permanent operator.

V. CONCLUSION

The statutory receivership presents a potentially powerful mechanism for the reform of substandard facilities. Each of the four

statutes examined, however, suffers from flaws concerning the right to petition for a receivership, the grounds for appointment of a receiver, and the powers of the receiver. They also devote insufficient attention to the termination of the receivership and provide ineffective planning for reimbursement of the receiver.

Because the court-appointed receiver holds considerable discretionary power, a court order can remedy several major deficiencies in the statute. Courts, therefore, should pay close attention to arranging realistic measures for reimbursing the receiver for its expenses. Substandard facilities often have poorly managed financial arrangements and, consequently, they lose large sums of money. As a result, the income from the facility may be insufficient to reimburse the receiver for necessary expenses. Depending on the provisions of the particular statute and the financial status of the facility, counsel for a private receiver should consider securing the following provisons in a court order as conditions of appointment as receiver: (1) the owner or operator shall post a bond to cover potential deficits; (2) any reasonable deficit not reimbursed by the operator shall be reimbursed by the state, because in most states the receiver acts as the state's designee; and (3) the facility shall be assisted in making expedited application for Medicare and Medicaid reimbursement if this will supplement the income of the home. In addition, the court should grant the receiver expanded powers in cases in which the facility has a strong potential for rehabilitation and the receiver has expertise in nursing home administration. Finally, the court should set definite milestones and deadlines leading to a planned termination of the receivership.

While the proper legal framework for an effective receivership is established by statute and court order, the rehabilitation of the facility depends on a concerted effort outside the courtroom. An imporant step toward success is achieved when a private party undertakes the receivership. Thereafter, the key factor, as illustrated by the experience of the Village Nursing Home, is broad community participation. The increased community interest in nursing homes, especially following enactment of reformed nursing home laws, and the inclusion of the statutory receivership provision in the new laws, may create a climate in which the success of the Village Nursing Home can be repeated.