



Behind the Curtains:

Corporate Control and Care in Wisconsin Nursing Homes





Whether representing injured nursing home residents, defending nursing homes, or advising such institutions on governance and compliance, lawyers must analyze how ownership and control affect day-to-day operations, staffing decisions, and regulatory oversight. This article examines those dynamics with a particular focus on the risks posed by profit-driven ownership models and the legal implications for attorneys navigating them.

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Corporate ownership and control are central to how liability, accountability, and compliance are understood across all areas of law. Understanding ownership and the implications of ownership structures is crucial to constructing claims and strategizing a case. Corporate structure, in any area of law, shapes decision-making authority, determines access to assets, and influences both liability exposure and potential damages. Framing a case around corporate control is key for effective litigation.

Developments in the nursing home industry highlight the effect of certain ownership structures on both liability and damages, including the impact they can have on an entire industry. An industry that once consisted largely of community-based facilities owned and operated by local residents or organizations is now dominated by corporate chains, private equity firms, and real estate investment trusts. Ownership changes are increasingly frequent, complex, and opaque, often leaving residents and their families uncertain about who ultimately makes the decisions that shape care.

Between 2016 and 2021, while approximately 348 hospitals changed ownership, more than 3,000 nursing homes did so – nearly 10 times as many.¹ By the end of 2022, the 10 largest nursing home chains owned over 10% of all facilities nationally, raising concerns about concentration of market power.² In Wisconsin, news reports of nursing home receiverships, including the 2025 court-ordered takeover of four facilities operated by Bedrock Healthcare, illustrate how financial instability at the corporate level can ripple directly into resident care.³

For attorneys, understanding these ownership structures is not merely an academic exercise. Whether representing injured residents, defending providers, or advising institutions on governance and compliance, lawyers must analyze how ownership and control affect day-to-day operations, staffing decisions, and regulatory oversight. This article examines those dynamics with a particular focus on the risks posed by profit-driven ownership models – and the legal implications for attorneys navigating them.

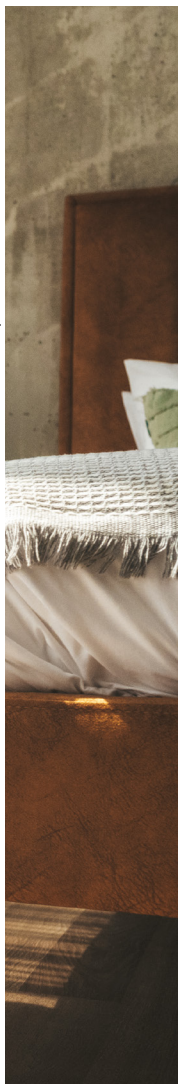
Ownership Structures: More Than Meets the Eye

A person examining a nursing home's license will see that rarely is there a single owner. Instead, facilities are commonly divided into separate legal entities:

- One limited liability company (LLC) holds the real estate.
- Another LLC manages day-to-day operations.
- Yet another entity may provide staffing or administrative services.

Ownership disclosures required by the Centers for Medicare & Medicaid Services (CMS) include categories such as “5% or greater direct ownership interest,” which identify additional individuals or entities with financial control. However, these disclosures and current provider enrollment data do not necessarily capture all individuals and entities that own, manage, or control nursing homes.

Beyond ownership, many services are outsourced to separate companies – therapy providers, dietary contractors, staffing agencies, or even nurse-practitioner groups – further blurring the lines of accountability. This fragmentation is deliberate. It limits liability exposure for parent



corporations and complicates litigation, regulatory enforcement, and even basic consumer understanding.

In Wisconsin, the Department of Health Services (DHS) requires disclosure of ownership and controlling interests under Wis. Stat. chapter 50.⁴ Yet these filings don't always give a full picture of the stakeholders who influence or control operations – particularly when external investment firms, real estate trusts, or subcontracted service providers are involved.

Without full disclosure, families, regulators, and attorneys may struggle to hold the correct entity accountable when a resident allegedly is harmed.

The Rise of For-Profit Ownership

The profile of nursing home ownership has changed dramatically in recent decades. In 2000, many Wisconsin facilities were still family owned or were operated by nonprofit organizations. Today, a significant portion are controlled by multistate corporations and investment firms, with over 70% of skilled nursing facilities being for profit. In recent years, the U.S. Government Accountability Office (GAO) warned that CMS ownership data remains too opaque.⁵

When ownership data is not transparent, it complicates accountability for quality failures. Lack of clarity makes it harder for families to know who is ultimately responsible, for regulators to enforce standards, and for attorneys to identify the right parties in litigation. At its core, transparency is not just a regulatory issue – it is about ensuring that the people making decisions behind the scenes can be held answerable for the consequences of those decisions.

Research increasingly confirms what health-care practitioners and attorneys have long observed: profit-driven ownership can negatively affect resident outcomes. A 2023 revised CMS-supported working paper examining 18,000 nursing homes over a 17-year period found that private equity ownership was associated with:

- a 10% increase in excess resident mortality,
- a 50% increase in antipsychotic prescriptions,
- a 3% decline in frontline nursing staffing, and
- an 11% increase in taxpayer spending per resident.⁶

Another study found that private equity-backed nursing homes experienced COVID-19 infection and death rates 30-40% higher than statewide averages.⁷

In Wisconsin, when financially distressed facilities change hands, quality often declines. In 2024, a surge in nursing home sales statewide corresponded with reduced staffing and increased deficiency citations.⁸

Another layer involves real estate investment trusts (REITs). In many ownership changes, corporations retain facility operations while selling the underlying property to REITs. It has been found that within two to three years after such transactions, registered nurse staffing often declines by as much as six percent.⁹

The decoupling of property ownership from operations creates conflicting incentives: operators must satisfy both resident needs and investor expectations. The result is often reduced reinvestment in care infrastructure and staff support.

Corporate Control Over Daily Operations

With private equity investment in health care dramatically increasing over the past several years, reaching 1,171 transactions worth a total of \$105.3 billion in 2020,¹⁰ commentators contend that underfunding of nursing homes, poorer care, and reduced staffing have resulted.

The most visible effect of corporate oversight is in staffing. Staffing levels – particularly the ratio of registered nurses to residents – are strongly correlated with quality of care.¹¹ Previous studies suggest that nearly 75% of U.S. nursing home residents live in facilities

that do not have a sufficient number of nurses to provide residents with safe, adequate care.¹²

When corporate entities such as private equity and real estate investment firms take control, facilities and their residents tend to suffer the consequences. Staffing is the single greatest operating expense for a nursing home, and it can be one of the first expenses targeted for reductions.

Payroll-based journal (PBJ) data, required by CMS, has highlighted patterns of understaffing, especially during nights and weekends.¹³ These patterns often align with corporate-driven scheduling practices rather than resident needs – for-profit nursing homes routinely determine staffing levels based on reimbursement and census rather than resident acuity.¹⁴

Beyond staffing, corporations influence whether facilities invest in updated equipment, staff training, or electronic health record systems. Investment in facility improvements – including staffing levels, resident equipment, and competitive pay for nursing staff – is often postponed by for-profit corporate owners to preserve profit margins, even when those investments could directly enhance resident safety.

Consequences for Resident Care

The effects of staffing reductions are not theoretical – they are measurable. CMS has consistently found that higher staffing levels, particularly registered



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nurse (RN) hours, are associated with fewer deficiencies and better resident outcomes.¹⁵ When corporate priorities focus on cost containment, staffing is often the first target.

The Wisconsin Administrative Code does not impose a blanket requirement that an RN be present at all times in every facility. Under Wis. Admin. Code section DHS 132.62, facilities must employ a full-time director of nursing services (who must be an RN) and must maintain a charge nurse on duty at all times. The code also sets size-based requirements; for example, smaller facilities may have an RN serve as the charge nurse during daytime shifts, while larger ones must maintain RN charge coverage on non-daytime shifts. A nursing home with 100 or more residents must have at least one RN, in addition to the director of nursing, on duty as charge nurse at all times. Beyond that, the regulation mandates that adequate

nursing personnel be assigned on each shift to meet each resident's specific needs and that staff "be briefed on the condition and appropriate care of each resident."¹⁶

These staffing minimums form the backbone of many civil claims. Plaintiffs' attorneys frequently allege that chronic understaffing violates both state and federal standards and foreseeably results in falls, pressure wounds, and other injuries. Defense attorneys, conversely, often rely on compliance documentation, staffing rosters, and PBJ data to demonstrate that staffing levels met regulatory requirements and industry norms.

In Wisconsin, DHS survey reports have repeatedly cited insufficient staffing as a root cause of falls, pressure injuries, and medication errors.¹⁷ The Bedrock Healthcare receivership highlighted this dynamic: chronic staffing shortages, which directly

affected resident care and worsened as the parent corporation faced financial collapse.¹⁸

Private equity ownership has been associated not only with reduced staffing but also with greater reliance on antipsychotic medications as a substitute for adequate caregiver attention. Research indicates that as staffing levels decline, the use of these drugs rises. The inappropriate use of antipsychotic medications in this context not only falls short of care standards but also increases the risk of mortality among nursing home residents.¹⁹

Corporate ownership is not always detrimental. Larger organizations can provide resources such as compliance programs, in-house counsel, and electronic monitoring systems that smaller facilities cannot match. But these tools often serve corporate risk management more than resident care, raising the question of whether they function

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as genuine safeguards or as part of a shell game designed to shield decision-makers while cutting costs of direct resident care.

Regulatory Oversight in a Corporate World

The risks to resident care naturally raise the question of oversight: Who is responsible for ensuring that facilities – and their corporate parents – are meeting the standards of care? Regulations provide a framework for accountability, but regulatory effectiveness is tested when ownership structures are layered and complex.

The Nursing Home Reform Act of 1987 set forth federal requirements for facilities participating in Medicare and Medicaid, including staffing adequacy, resident rights, and quality of care. Enforcement rests primarily with CMS, which contracts with state survey agencies.

In Wisconsin, the DHS licenses nursing homes, conducts inspections, and enforces compliance with both state and federal regulations.²⁰ Enforcement tools include deficiency citations and reports, directed plans of correction, and civil monetary penalties.

Public reporting has also highlighted facilities with repeated quality failures linked to ownership changes, underscoring the limits of enforcement in practice. At the same time, it is important to note that DHS and nursing home investigation materials created for the purpose of peer review are generally inadmissible in Wisconsin civil litigation.²¹

Oversight also has structural limits: Enforcement often stops at the facility level, with civil monetary penalties typically levied against the operating entity rather than the corporate parent – even when key decisions were made higher up the chain. This disconnect can create accountability gaps.

CMS has begun to respond. In late 2022, it finalized a Nursing Home

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Ownership Transparency Rule, which took effect in January 2024. The rule requires enhanced disclosures of ownership, private equity involvement, and management control.²² The rule remains in effect, although future administrations may seek to alter or scale back its enforcement. The agency has also expanded its Special Focus Facility (SFF) program, which monitors chronically underperforming facilities, many of which are owned by chains with repeat deficiencies.²³

These regulatory efforts reflect a growing recognition that ownership and financial structures play a central role in care quality. For attorneys, this evolving landscape underscores the importance of understanding not only facility operations but also the corporate and financial frameworks that shape them.

Legal and Practical Implications for Attorneys

Corporate ownership structures are not an abstract regulatory concern – they shape how liability is argued, how compliance is evaluated, and how attorneys on all sides must approach their cases.

For plaintiffs' counsel, identifying all responsible parties is crucial. Corporate layering requires careful examination of DHS licensure records, CMS ownership databases, and public filings to determine who truly controls operational and financial decision-making. The hierarchy of authority – where policy originates versus where it is implemented – often determines whether a claim is framed as simple negligence or systemic corporate misconduct. Patterns uncovered through discovery can reveal whether cost-saving measures, staffing directives, or resource limitations were

driven by business imperatives at the corporate level rather than by clinical judgment exercised by individuals inside the facility. When that occurs, questions of control, foreseeability, and corporate knowledge move to the forefront of liability analysis.

From the defense perspective, these arguments about corporate control are now common in litigation. Ownership transparency and documentation practices are increasingly scrutinized, and disputes often turn on how much authority truly rested with local administrators versus parent companies. Demonstrating that decision-making was appropriately delegated can be a decisive factor in limiting exposure. The challenge for defense counsel is to reconcile operational autonomy with corporate-oversight obligations: maintaining enough consistency to satisfy regulators and investors while preserving evidence that care decisions were made based on residents' individualized needs rather than profit or policy.

For attorneys advising facilities outside of litigation, proactive governance measures are essential: ensuring facility-level leaders have real authority and budgetary discretion, documenting delegation of control, and monitoring corporate policies for compliance with resident-rights and staffing requirements. Encouraging periodic internal audits based on Wis. Admin. Code chapter DHS 132 and CMS quality measures can mitigate enforcement risk.

Attorneys should also be familiar with the governing legal framework:

- Wis. Stat. chapter 50 regulates licensing and resident rights in residential facilities.

- Wis. Admin. Code chapter DHS 132 provides the administrative standards for nursing homes, including staffing, training, infection control, and resident-care requirements.

- Wis. Admin. Code chapter DHS 83 governs community-based residential facilities (CBRFs).

- 42 C.F.R. chapter 483 establishes federal participation and quality-of-care requirements for skilled nursing facilities (nursing homes) participating in Medicare and Medicaid.

In Wisconsin, DHS survey reports have revealed several recurring areas of noncompliance that might later form the basis of civil actions or defenses:

- Failure to prevent falls or elopement,
- Failure to prevent or treat pressure injuries,
- Neglect leading to malnutrition or dehydration,
- Improper use of physical or chemical restraints,
- Medication administration errors or failure to monitor adverse reactions, and
- Resident-rights violations.²⁴

For attorneys, cross-referencing cited deficiencies ("Tags") from DHS survey results with alleged injury timelines can help establish – or refute – patterns of

systemic neglect. These deficiencies can provide an adequate roadmap for either party, although counsel should keep in mind that DHS and nursing home investigation materials created for the purpose of peer review are generally inadmissible in Wisconsin civil litigation.

Taken together, these enforcement findings and regulatory patterns demonstrate that nursing home litigation in Wisconsin increasingly turns on the intersection of corporate policy and resident-level care. As in other practice areas, ownership and control remain central to how liability, accountability, and compliance are understood. The same corporate structures that determine access to assets and decision-making authority within a single facility can also influence damages awards and defenses across an entire chain of providers.

Understanding how these layers of ownership, staffing decisions, and regulatory compliance intertwine is

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Pelishek v. City of Sheboygan, 23-CV-1048, 2025 WL 2675094 (E.D. Wis. Sept. 18, 2025). Finding misrepresentations both of law and fact in the plaintiff's submissions, the court ordered plaintiff's counsel to show cause why sanctions, including dismissal of plaintiff's actions should not be imposed pursuant to FRCP 11(c) and the court's inherent authority. The court found that "counsel has misrepresented what courts have said, what their own proposed findings of fact say, and what the record before this court says." A court should not impose sanctions simply to address persnickety frustration with the parties; however, the court must not shirk its obligation to impose sanctions when they are warranted. Mistakes happen. As the legal community adjusts to the promise and perils of artificial intelligence, even some courts have seemingly fallen victim to hallucinating artificial intelligence. But not all of the errors can be fairly attributed to inexperience. Inexperience may lead an attorney to employ ineffective systems for checking citations. But after identifying errors in legal citations, even the most inexperienced attorney should recognize the need to manually check every citation. Despite knowing that they were employing artificial intelligence in a way that may result in fabricated caselaw, plaintiff's attorneys submitted their briefs apparently without verifying all of their citations. Whether caused by misused artificial intelligence, misunderstanding the appropriate bounds of legal argument, simple sloppiness, or an intentional effort to mislead the court, misrepresentations of the law should never appear in any court filing. Significantly aggravating counsel's conduct is the fact that misrepresentations persisted after counsel recognized certain errors and amended their briefs. It is inexcusable that counsel would file amended briefs, correcting certain misrepresentations without comprehensively reviewing every citation and argument. The court ordered monetary sanctions but concluded that dismissal was both unnecessary and unduly harsh. While the sanctions represented only a small fraction of the value of the time that has been needlessly diverted to this matter, the sums were high enough to cross the threshold into sufficiency, which is to say that a significantly higher sanction would also have been reasonable. The court's public admonition also serves as deterrence.

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essential not only for litigating existing cases but also for anticipating emerging liability trends. Those dynamics – rooted in corporate control and its effect on care delivery – are now shaping national debates about transparency, minimum staffing standards, and accountability, discussions that are poised to redefine the future of long-term care.

Looking Ahead: National Trends and Lasting Implications

Despite mounting criticism, private equity and other for-profit investors continue to acquire nursing homes. Analysts predict that financial firms will remain active because of the steady reimbursement streams from Medicaid and Medicare. For Wisconsin, this trend signals further instability unless stronger transparency and staffing protections are enacted.²⁵

Federal regulators have taken steps to address these concerns. CMS

finalized a national minimum-staffing rule in 2024 and broadened ownership disclosure requirements.²⁶ The staffing mandate has faced significant legal and political challenges, and a 10-year moratorium was imposed on the implementation and enforcement of the entire rule earlier this year. Despite the moratorium and discussions of CMS's intent to repeal the rule, these regulatory efforts illustrate both the urgency of reform and the instability that comes with shifting political priorities.²⁷

At the same time, corporations are increasingly deploying data analytics to monitor staffing, quality measures, and litigation risk. While these tools can help identify problems early, they also risk reducing resident care to a set of metrics – sidelining the human needs that define quality of life in long-term care.²⁸

The larger point is clear: The operation of a nursing home cannot be understood solely by observing what

happens within its walls. Corporate structures, financial priorities, and ownership changes profoundly influence resident care and, by extension, legal accountability.

For attorneys across the spectrum, the message is straightforward – whether evaluating liability, advising providers, or shaping policy, look beyond the facility itself to the corporate parents and financial stakeholders who drive decision-making.

This is not only a Wisconsin issue. It reflects a national shift in how long-term care is financed and delivered, with consequences that extend well beyond any single facility or state. As this transformation continues, attorneys, policymakers, and communities will need to weigh how best to protect residents while recognizing the realities of an increasingly corporate model of care. **WL**

ENDNOTES

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⁷GAO, *supra* note 5; CMS, *Disclosures of Ownership*, *supra* note 1.

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¹⁶Wis. Admin. Code § DHS 132.62.

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