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## **HHS 'NURSING HOME COMPARE' WEBSITE HAS MAJOR FLAWS**

**PREPARED FOR REP. HENRY A. WAXMAN AND SEN. CHARLES E. GRASSLEY**

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Committee on Government Reform:  
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## EXECUTIVE SUMMARY

At the request of Rep. Henry A. Waxman and Sen. Charles E. Grassley, this report examines ‘Nursing Home Compare,’ the government website that disseminates information about conditions in individual nursing homes. The report finds that ‘Nursing Home Compare’ has major flaws that can mislead families seeking to find a safe nursing home. The data on ‘Nursing Home Compare’ does not include tens of thousands of recent violations of federal health standards, including nearly 60% of the violations involving death or serious injury. Many nursing homes with documented violations of federal health standards are incorrectly portrayed on ‘Nursing Home Compare’ as complying with federal standards.

The ‘Nursing Home Compare’ website, which is maintained by the Department of Health and Human Services, is used by millions of families. The website receives approximately 100,000 visits a month and is one of the most popular destinations for individuals who view the Medicare homepage. The most important information on the site is a searchable database that allows the public to determine the compliance status of virtually any nursing home in the United States.

On the front page of ‘Nursing Home Compare,’ HHS states that “the primary purpose of this tool is to provide the public with detailed information about the performance of every Medicare and Medicaid certified nursing home in the country.” In a recent \$30 million ad campaign, HHS advertised the site as being “filled with reliable health care information . . . [to] help you . . . locate nursing homes for yourself or a loved one.” Contrary to these assertions, however, the data in ‘Nursing Home Compare’ actually excludes many documented violations of federal health standards.

The HHS website contains violations found during annual inspections of nursing homes conducted by state officials. But it does not contain any violations found during complaint investigations conducted by the same state officials. Between October 1, 2000 and December 31, 2001, states investigated approximately 52,000 complaints about conditions in nursing homes. These state complaint investigations resulted in 25,204 documented violations of federal health standards. All of these 25,204 violations of federal standards are excluded from ‘Nursing Home Compare.’

The exclusion of the violations found during complaint investigations means that the HHS website provides unreliable information to the public. The most severe nursing home violations are “immediate jeopardy” violations, which are defined as violations that cause or have the potential to cause death or serious injury to residents. Between October 1, 2000, and December 31, 2001, nursing homes in the United States were cited for 1,923 immediate jeopardy violations. ‘Nursing Home Compare,’ however, contains data on only 785 of these violations. Most of the immediate jeopardy violations -- 1,138 violations (59% of the total) -- were discovered during complaint investigations. They are not disclosed to the public on ‘Nursing Home Compare.’

During the same period, nursing homes were cited during complaint investigations for

4,406 violations that caused “actual harm” to residents. These 4,406 actual harm violations represent 41% of the total number of actual harm violations cited by state inspectors, but they are also excluded from ‘Nursing Home Compare’ because they were found during complaint investigations. In total, ‘Nursing Home Compare’ excludes 23,092 nursing home violations cited during complaint inspections from October 1, 2000, to December 31, 2001, that had at least the potential to harm residents, as well as 2,112 minor violations that posed no harm to residents.

One of the consequences of excluding the results of complaint investigations is that the compliance status of many nursing homes is incorrectly portrayed on ‘Nursing Home Compare.’ There are 871 nursing homes in the United States that were cited for immediate jeopardy violations between October 1, 2000 and December 31, 2001. Over half of these nursing homes (471 facilities) are not identified on ‘Nursing Home Compare’ as having any immediate jeopardy violations. Over 1,300 nursing homes that had actual harm violations are misidentified on ‘Nursing Home Compare’ as having no actual harm violations.

This report reviewed the results of complaint investigations for over 60 nursing homes that were listed on the HHS website as meeting all federal standards or having at most only minor violations that posed no risk to residents. This review showed that many of these nursing homes actually had extremely serious violations that were not disclosed on ‘Nursing Home Compare,’ including violations that caused the death of residents. One undisclosed violation involved a nursing home that failed to properly treat a resident with a graft on his arm. When an aneurysm at the graft site ruptured, the resident died in “a river of blood.” In another undisclosed violation, a nursing home failed to administer a physician-ordered urinalysis and failed to adequately monitor a resident with a urinary tract infection. The resident’s condition progressively worsened until she suffered a “precipitous drop in blood pressure,” was taken to the hospital, and was unable to be revived.

In other cases, nursing homes that were portrayed on ‘Nursing Home Compare’ as having excellent compliance histories actually had undisclosed violations involving serious abuse and mistreatment of residents. ‘Nursing Home Compare’ did not disclose that a staff member at one nursing home exposed himself to a female resident on repeated occasions. In other cases, ‘Nursing Home Compare’ did not disclose that nursing homes failed to provide basic care to residents, allowed residents to wander from the nursing facility and remain outside in freezing conditions, and failed to treat residents with obviously broken bones. Other undisclosed violations resulted in serious injury to residents, including a fractured hip, a fractured leg, a fractured arm, a fractured wrist, and a fractured skull.

## I. USE OF ‘NURSING HOME COMPARE’ BY THE PUBLIC

The Department of Health and Human Services launched the ‘Nursing Home Compare’ website in 1998 to provide the public with information about conditions in nursing homes that serve Medicare or Medicaid beneficiaries. Virtually all nursing homes in the United States serve these beneficiaries and are listed on ‘Nursing Home Compare.’ Information on over 16,000 nursing homes is currently provided on the site.

‘Nursing Home Compare’ is accessed by the public through the main Medicare website, [www.medicare.gov](http://www.medicare.gov). On the front page of ‘Nursing Home Compare,’ the public is informed that “the primary purpose of this tool is to provide detailed information about the performance of every Medicare and Medicaid certified nursing home in the country.”<sup>1</sup>

Millions of citizens rely on ‘Nursing Home Compare’ to obtain information about nursing homes. The ‘Nursing Home Compare’ website is one of the most popular destinations on the main Medicare homepage. It receives approximately 100,000 visits monthly.<sup>2</sup>

When the news media reports on problems in nursing homes, they frequently refer the public to ‘Nursing Home Compare’ as a resource for obtaining additional information.<sup>3</sup> For example, the *Washington Post* reported that “searching for a nursing home has been made simpler thanks to the nursing home database. . . . [O]ne of the directory’s best benefits [is] the ability to get the latest nursing home inspection reports.”<sup>4</sup> *USA Today* told readers that the HHS site “shows comparative information about individual nursing homes, including annual inspection reports. . . . [S]uch information is an indispensable comfort.”<sup>5</sup> Other newspapers have noted that “anyone who needs a nursing home should browse . . . Nursing Home Compare,”<sup>6</sup> and have called the website “a great resource”<sup>7</sup> and “an essential tool.”<sup>8</sup>

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<sup>1</sup>Department of Health and Human Services, “Nursing Home Compare” website (2001) (online at [www.medicare.gov/nhcompare](http://www.medicare.gov/nhcompare)).

<sup>2</sup>Center for Medicare and Medicaid Services, *Medicare.gov Summary Statistics* (January 2002).

<sup>3</sup>In previous analyses of nursing home quality, the Special Investigations Division has also recommended the ‘Nursing Home Compare’ website. See, eg., U.S. House of Representatives, Committee on Government Reform, Minority Staff, *Abuse of Residents is a Major Problem in U.S. Nursing Homes* (July 30, 2001).

<sup>4</sup>*Web Site Has Data on Nursing Homes*, *Washington Post* (Oct. 19, 1999).

<sup>5</sup>*Notes from a Tour of Purgatory’s Barracks*, *USA Today* (Apr. 26, 2000).

<sup>6</sup>*Surf for Your Health*, *St. Petersburg Times* (June 27, 2000).

<sup>7</sup>*Take Care in Quest for a Nursing Home*, *Hartford Courant* (Apr. 8, 2001).

<sup>8</sup>*Web Helpful in Search for Nursing Homes*, *Minneapolis Star Tribune* (July 26, 2000).

Recently, the ‘Nursing Home Compare’ website has been heavily promoted by HHS as part of a \$30 million print and television campaign.<sup>9</sup> For example, in full page advertisements that appeared in *Parade* magazine, the *New York Times*, the *Washington Post*, the *Wall Street Journal*, and *U.S. Weekend* magazine, HHS advertised the medicare.gov website with the slogan “Helping you help yourself” and claimed that the medicare.gov website was “filled with reliable health care information. This valuable resource can help you . . . locate nursing homes for yourself or a loved one.”<sup>10</sup>

## II. DATA INCLUDED IN ‘NURSING HOME COMPARE’

The heart of ‘Nursing Home Compare’ is a searchable database. The public can search for information about individual nursing homes by state, county, city, and zip code. The searchable database contains information on nursing home characteristics (such as the number of residents and ownership type); resident characteristics (such as the number of residents suffering from pressure sores or the number of residents who have difficulty walking); staffing levels in the nursing homes; and information on the results of annual inspections conducted by state regulatory authorities.

The most important information on ‘Nursing Home Compare’ is the data on the compliance status of nursing homes. This data comes from annual inspections conducted by state inspectors and compiled by the Center for Medicare and Medicaid Services (CMS),<sup>11</sup> a division of HHS. CMS contracts with states to conduct annual inspections of nursing homes to determine if they are complying with federal requirements. During these inspections, the state inspection team interviews a sample of residents, staff members, and family members. The inspection team also reviews a sample of clinical records. Violations of federal standards observed by the inspectors are reported to the states, transmitted by the states to CMS, and summarized by CMS on the ‘Nursing Home Compare’ website.<sup>12</sup>

When a violation is found, the state inspection team writes a detailed description of the circumstances of the violation and its impact on nursing home residents on a form known as CMS Form 2567. Nursing home inspectors use a ranking system in order to identify the violations that pose the greatest risk to residents. The rankings are based on the severity (degree of actual harm to residents) and the scope (the number of residents affected) of the violation.

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<sup>9</sup>HHS, Medicare Fact Sheet, *Helping Beneficiaries Become Active Participants in their Own Health Care With the Medicare Education Campaign* (October 2001).

<sup>10</sup>CMS Advertisement, *Your Link to Medicare is Just a Click Away* (2001).

<sup>11</sup>Until July 2001, CMS was known as the Health Care Financing Administration, or HCFA.

<sup>12</sup>There are two sets of standards for nursing homes: health standards, that cover the quality of care and living conditions of residents, and safety standards, that are designed to ensure that the physical infrastructure of the buildings is safe (for example, whether the building has enough fire exits). This report, which focuses on living conditions for residents, analyzed only the health standards.

Each violation is given a letter rank, A to L, with A being the least serious (an isolated violation that poses minimal risks to residents) and L being the most serious (a widespread violation that causes or has the potential to cause death or serious injury). Violations in categories A, B, or C are those that pose no risk to residents, and homes with these violations only are considered to be in “substantial compliance” with the law. Violations in categories D, E, or F are those that have the potential to cause “more than minimal harm” to residents. Violations in categories G, H, or I are those that cause “actual harm” to residents. And violations in categories J, K, or L, also known as immediate jeopardy violations, are those that cause or have the potential to cause death or serious injury to residents.

This annual inspection data is summarized in ‘Nursing Home Compare.’ Information on any violations found in the most recent annual inspection of a nursing home is available on the site. In addition, users of ‘Nursing Home Compare’ can follow links to obtain the results from the two prior annual inspections. The site provides a general description of the category and type of violation. For example, if a nursing home failed to treat residents in an adequate manner to prevent bed sores, the website will note this under the category of “Quality Care Deficiencies.” Similarly, if a nursing home was responsible for medication errors, such as giving residents the wrong medication, the website will note this under the category of “Pharmacy Service Deficiencies.”

Additional information on the severity and scope of the violation is provided graphically. Violations are broken up into four severity categories ranked from 1 to 4. Violations in categories A, B, or C, which are violations that pose no risk to residents, are ranked 1. Violations in categories D, E, or F, which are violations that have the potential to harm residents, are ranked 2. Violations in categories G, H, or I, which are violations that cause “actual harm” to residents, are ranked 3. And violations in categories J, K, or L, which are violations that place residents in “immediate jeopardy,” are ranked 4. These rankings are presented for each violation. In addition, the website notes whether each violation affected “few,” “some,” or “many” residents.

Appendix I provides an example of how ‘Nursing Home Compare’ displays information about a nursing home with no violations; Appendix II provides an example of how ‘Nursing Home Compare’ displays information about a nursing home with minor violations; and Appendix III provides an example of how ‘Nursing Home Compare’ displays information about a nursing home with serious violations.

### **III. DATA EXCLUDED FROM ‘NURSING HOME COMPARE’**

Although HHS claims that ‘Nursing Home Compare’ provides “detailed information about the performance of every Medicare and Medicaid certified nursing home,”<sup>13</sup> the HHS

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<sup>13</sup>Department of Health and Human Services, ‘Nursing Home Compare’ website (2002) (online at [www.medicare.gov/NHcompare/home.asp](http://www.medicare.gov/NHcompare/home.asp)).

website in fact excludes information on many documented health violations in these nursing homes. This information is missing because 'Nursing Home Compare' does not include the results of complaint investigations conducted by state inspectors.

Under HHS regulations, states are required to investigate all complaints alleging immediate jeopardy to a nursing home resident within two working days, and all complaints alleging actual harm to a nursing home resident within ten working days.<sup>14</sup> These complaint investigations are initiated when a nursing home resident, family member, employee, or other individual files a formal complaint with a state regulatory agency. Between October 1, 2000, and December 31, 2001, states investigated approximately 52,000 complaints about conditions in nursing homes. The complaint investigations are similar to the annual inspections included in 'Nursing Home Compare.' The investigations, which focus on the specific allegations in the complaint, are conducted by the same inspectors using the same methods as in the annual inspections. Violations are reported in the same way, and the same ranking system is used. As in the case of annual inspections, CMS provides funding for state complaint investigations.

As with violations found during annual inspections, violations found during complaint investigations are reported to the states and transmitted by the states to CMS. CMS then compiles the violations into a federal database. But unlike the results of annual inspections, the information on violations found during complaint investigations is not posted on the 'Nursing Home Compare' website. These excluded complaint violations are not mere allegations. They are complaints that have been substantiated by state inspectors and have resulted in citations for the nursing homes.

#### **IV. PURPOSE AND METHODOLOGY**

Rep. Henry A. Waxman and Sen. Charles E. Grassley asked the Special Investigations Division of the minority staff of the Committee on Government Reform to investigate the impact of excluding violations cited during complaint investigations from 'Nursing Home Compare.' This report presents the results of the investigation. It is the first report to analyze the completeness and reliability of the data on 'Nursing Home Compare.'

To conduct this analysis, the Special Investigations Division obtained the 'Nursing Home Compare' database of annual inspection results from HHS. This database was updated through December 31, 2001. For over 90% of the nursing homes in the database, the most recent annual inspection was conducted between October 1, 2000, and December 31, 2001. The Special Investigations Division also obtained the database of the results of complaint investigations from HHS. This database included information on all violations cited during complaint investigations that occurred between October 1, 2000, and December 31, 2001. The two data sets were then compared in order to determine the impact of the omission of the complaint data from 'Nursing

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<sup>14</sup>42 C.F.R. § 488.332. See GAO, *Nursing Homes: Complaint Investigation Process Often Inadequate to Protect Residents*, 4, 58-59 (March 1999).



Home Compare.’

## V. FINDINGS

The exclusion of violations found during complaint investigations renders ‘Nursing Home Compare’ incomplete and misleading. During the period from October 1, 2000, to December 31, 2001, state inspectors conducting complaint investigations cited nursing homes for 25,204 violations of federal health standards. The public can find no information about any of these violations on ‘Nursing Home Compare.’

### A. Undisclosed “Immediate Jeopardy” Violations

The most serious nursing home violations are those that cause death or serious injury to nursing home residents or have the potential to do so. These are classified as “immediate jeopardy” violations by nursing home inspectors.

The failure to include the results of complaint investigations in ‘Nursing Home Compare’ has a major impact on the disclosure of immediate jeopardy violations. During the 15-month period examined in this report, state inspectors cited nursing homes in the United States for 1,923 immediate jeopardy violations. But nearly three of every five violations -- 1,138 violations (59%) -- were discovered during complaint investigations. None of these violations are disclosed to the public through ‘Nursing Home Compare.’

During the 15-month period between October 1, 2000, and December 31, 2001, 871 nursing homes in the United States were cited for immediate jeopardy violations. But in the case of 471 of these nursing homes, there is no indication on ‘Nursing Home Compare’ of any immediate jeopardy violations. A member of the public relying on ‘Nursing Home Compare’ to assess the compliance status of any of these 471 nursing homes would be unaware that state inspectors found that the nursing home had a recent violation that caused (or had the potential to cause) death or serious injury to nursing home residents.

**Table 1: Thousands of Nursing Homes Were Cited for Violations During Complaint Investigations Between October 1, 2000, and December 31, 2001.**

<b>Most Severe Violation Cited by Inspectors</b>	<b>Number of Homes</b>	<b>Percent of Homes</b>	<b>Number of Violations</b>
Potential for Minimal Harm	246	2%	2,112
Minimal Harm or Potential for Actual Harm	3,304	20%	17,548
Actual Harm to Residents	2,166	13%	4,406
Immediate Jeopardy -- Actual or Potential Death/Serious Injury	562	3%	1,138
Any Complaint Violation	6,277	38%	25,204

## **B. Undisclosed “Actual Harm” Violations**

The second most serious type of nursing home violations are those that cause actual harm to residents. In this area too, the exclusion of the complaint data distorts the information presented in ‘Nursing Home Compare.’

During the period from October 1, 2000, to December 31, 2001, state inspectors conducting complaint investigations cited nursing homes for 4,406 actual harm violations. In comparison, state inspectors conducting annual inspections cited nursing homes for 6,437 actual harm violations during this period. The exclusion of violations from complaint investigations means that 41% of the actual harm violations documented by state inspectors are not included in ‘Nursing Home Compare.’

The actual harm violations that are excluded from ‘Nursing Home Compare’ include many serious violations. The most frequently cited actual harm and immediate jeopardy violations that are omitted from ‘Nursing Home Compare’ include the failure to take appropriate actions to prevent accidents (1,136 violations); the abuse of residents or the failure to take appropriate actions to prevent abuse (711 violations); the failure to give residents proper treatment to prevent new bed sores or heal existing ones (580 violations); and the failure to provide adequate nutrition or hydration for residents (268 violations).

The failure to include actual harm violations from complaint investigations affects how the compliance status of over 1,300 nursing homes is displayed on ‘Nursing Home Compare.’ The actual harm violations discovered during annual inspections and complaint investigations occurred in 4,385 nursing homes. But only 3,039 of these homes have an actual harm violation on ‘Nursing Home Compare.’<sup>15</sup> For the remaining 1,346 homes, there is no indication on ‘Nursing Home Compare’ that the facility has been cited by state inspectors for an actual harm violation.

## **C. Other Undisclosed Violations**

State inspectors cited also nursing homes for 17,548 complaint violations that caused minimal harm or had the potential to cause actual harm to residents, and 2,112 complaint violations that posed the potential for minimal harm to residents during the 15-month period from October 1, 2000, to December 31, 2001. None of these violations was included in ‘Nursing Home Compare.’ In total, nursing home inspectors conducting complaint investigations cited nursing homes for 25,204 violations of federal health standards during this period. Over 90% of these violations, 23,092 violations, harmed or had the potential to harm residents. None of these

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<sup>15</sup>Even for these nursing homes, “Nursing Home Compare” provides information only on the actual harm violations found during annual inspections. The site contains no information on the violations found during complaint investigations.

violations are included in 'Nursing Home Compare.' Table 1 shows the severity of these violations, as well as the number and percent of homes affected.

#### **D. Nursing Homes That Incorrectly Appear to Comply with Federal Standards**

HHS considers a nursing home to be in compliance with federal health standards if it has no violations of federal health standards. HHS considers a nursing home to be in "substantial compliance" if it has only minor violations that pose no risk to residents. According to the data presented to the public through 'Nursing Home Compare,' there were 2,549 nursing homes that were in compliance or substantial compliance with federal standards as of December 31, 2001. According to 'Nursing Home Compare,' none of these 2,549 nursing homes had immediate jeopardy, actual harm, or potential-to-harm violations.

In fact, however, many of these nursing homes actually had recent violations that were documented by inspectors conducting complaint investigations, but were not included in 'Nursing Home Compare.' Almost one-fifth of these nursing homes (471 facilities) were cited during complaint investigations for violations that had at least the potential to harm residents. In 197 of these nursing homes, the violations were serious enough to cause actual harm to residents.

#### **E. Interpretation of Results**

The analysis in this report should be considered a "snapshot" of the effect of excluding the results of complaint investigations from 'Nursing Home Compare.' This report is based on (1) data posted on the 'Nursing Home Compare' website as of December 31, 2001, and (2) data from complaint investigations conducted from October 1, 2000, through December 31, 2001. State inspectors are constantly conducting new complaint or annual inspections, and the data on 'Nursing Home Compare' is regularly updated by CMS. As a result, the exact numbers of violations included or excluded from 'Nursing Home Compare,' as well as the compliance status of individual nursing homes, changes over time. Until HHS changes its policies, the problems with 'Nursing Home Compare' that are identified in this report will continue to exist, but the current conditions at any individual nursing home may be different today than on December 31, 2001.

There are additional reasons why 'Nursing Home Compare' may underreport violations at nursing homes besides its failure to include the results of complaint investigations. One problem is that state inspectors often miss significant violations. A recent report by the U.S. General Accounting Office found that when federal inspectors inspect nursing homes after state inspectors, the federal inspectors find more serious care problems than the state inspectors in 70% of the nursing homes. The federal inspectors also find many more violations of federal health standards.<sup>16</sup> Another problem, according to GAO, is that "homes could generally predict

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<sup>16</sup>GAO, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, 43 (September 2000).

when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations.”<sup>17</sup> Consequently, this report may underestimate the number of violations and the number of quality of care problems that are not included in ‘Nursing Home Compare.’

## **VI. EXAMPLES OF MISLEADING INFORMATION**

At the request of Rep. Waxman and Sen. Grassley, the Special Investigations Division reviewed in detail results from complaint investigations of over 60 nursing homes. According to the data in ‘Nursing Home Compare’ as of December 31, 2001, each of these nursing homes had either no violations of federal standards or at most only minor violations that posed no risk to residents. The complaint investigations reviewed by the Special Investigations Division were conducted after October 1, 2000, but prior to December 31, 2001.

This review revealed that many of the nursing homes actually had serious health violations. In several instances, the violations documented by state inspectors during complaint investigations resulted in the death of residents. In other instances, they involved abuse or other mistreatment of residents. In no instance were the serious violations cited during complaint investigations disclosed to the public through the ‘Nursing Home Compare’ website.

Table 2 summarizes some of these undisclosed violations.

### **A. Nursing Homes with Violations Involving Death of Residents**

According to the data in ‘Nursing Home Compare’ on December 31, 2001, a nursing home in Fort Worth, Texas, appeared to be a model facility. ‘Nursing Home Compare’ reported that the facility had no violations that posed a risk of harm to residents. Based on the data disclosed to the public through ‘Nursing Home Compare,’ the nursing home would be considered in substantial compliance with federal health standards.

In fact, however, the facility had been cited in August 2001 for a serious violation that led to the death of a resident. A resident in the nursing home bled to death after staff members failed to properly monitor him or implement key procedures when they found him on the floor of his room bleeding. According to state inspectors, the nursing home failed to properly assess and monitor a graft on the resident’s right arm, allowing an aneurysm at his graft site to rupture. Responding to cries of “Help me, help me, help me” a nurse ran to his room and described what she saw: “It was a grotesque picture. There was a river of blood from the top of the bed to the bottom. . . . He said, ‘help me’ again very weakly.” None of the four nurses who witnessed the resident bleeding applied pressure to the wound area or performed CPR. Fire department officials explained that when they arrived, staff members were in the hall, not in the room with the resident. The resident was pronounced dead at the hospital.<sup>18</sup>

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<sup>17</sup>GAO, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, 4 (July 1998).

<sup>18</sup>HCFA Form 2567 for Nursing Home in Fort Worth, TX (Aug. 15, 2001) (G-level violation).

**Table 2: Examples of Violations Cited During Complaint Investigations But Not Included on ‘Nursing Home Compare’**

<b>Nursing Home Location</b>	<b>Severity (and Date) of Violation</b>	<b>Description of Violation</b>
Fort Worth, TX	Immediate Jeopardy (August 15, 2001)	Nursing home fails to properly assess and monitor a graft on a resident’s arm. The resident dies in a “sea of blood” after an aneurysm at the graft site ruptures. Staff failed to implement key procedures after the incident, including failing to apply pressure to the wound or performing CPR on the resident.
New Orleans, LA	Actual Harm (February 9, 2001)	Nursing home fails to administer a physician-ordered urinalysis to a resident who had a history of infections. Family members found the resident “groaning and yelling” and requested that she be taken to the emergency room. Her condition continued to decline, and she was pronounced dead in the hospital.
Whitney, TX	Actual Harm (July 6, 2001)	A nurses aide exposed himself to a female resident on repeated occasions. The nursing home failed to report and investigate the allegation, failed to initiate appropriate intervention, and failed to call the police.
Chicago, IL	Immediate Jeopardy (May 25, 2001)	Nursing home failed to properly monitor a resident with a history of wandering and failed to respond to a door alarm, allowing him to exit the building and spend over 13 hours outside on a 26 degree February night. The resident was admitted to the hospital with hypothermia, metabolic acidosis, and dehydration.
Lake View, IA	Actual Harm (November 9, 2000)	Nursing home repeatedly failed to protect vulnerable residents from falls. One resident was allowed to fall seven times in six months, sustaining multiple injuries. Another resident also fell multiple times due to the failure of the facility to implement proper care and supervision. On one occasion, a resident was found lying in the hallway with “the resident’s head . . . in a pool of red fluid (blood), and red liquid (blood) . . . coming from the resident’s mouth, nose and above the left eyebrow.”

In a second nursing home, the data in ‘Nursing Home Compare’ on December 31, 2001, indicated that the facility had no violations of federal health standards. Based on the data disclosed to the public through ‘Nursing Home Compare,’ the nursing home would be considered in complete compliance with federal health standards. In fact, however, the nursing home was cited for a serious violation in February 2001 that led to a fatality. The home failed to administer a physician-ordered urinalysis for a resident who had a history of urinary tract infections (and was suffering from such an infection at the time) and failed to monitor the resident properly as her condition deteriorated. Family members found her “groaning and yelling” one morning and as her level of consciousness decreased, they requested that she be taken to the emergency room. She suffered a “precipitous decline in her blood pressure,” was unable to be revived, and was pronounced dead at the hospital.<sup>19</sup>

**B. Nursing Homes with Violations Involving Abuse and Mistreatment of Residents**

According to the data in ‘Nursing Home Compare’ on December 31, 2001, a nursing home in Whitney, Texas, had only minor violations that posed no risk to residents. As a result, the facility appeared to be in substantial compliance with federal nursing home standards. The data on ‘Nursing Home Compare’ failed to disclose, however, that the nursing home had been cited in July 2001 for a serious sexual abuse violation. According to the state inspection report, a nurses aide took his penis out of his pants, “was swinging it at” a female resident, and “made her touch his penis.” The resident’s husband reported the incident and he also indicated that a similar incident with the same aide had occurred a few months before. The home failed “to immediately report and investigate” the allegation, failed “to take appropriate interventions to protect residents,” and failed to notify the police. During questioning by local police, the nurses aide confessed that he had sexually abused the resident.<sup>20</sup>

‘Nursing Home Compare’ also failed to disclose cases where nursing homes were unable to prevent mistreatment of residents by other residents. In one instance, a complaint investigation showed that a nursing home failed to properly monitor numerous residents with aggressive behavior, resulting in the physical abuse of several residents. Various residents were “kicked,” “slapped,” “hit . . . in the face,” and “struck . . . on the jaw.”<sup>21</sup> Despite this violation, the nursing home was listed on ‘Nursing Home Compare’ as having only minor violations that posed no risk to residents.

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<sup>19</sup>HCFA Form 2567 for Nursing Home in New Orleans, LA (Feb. 9, 2001) (G-level violation).

<sup>20</sup>HCFA Form 2567 for Nursing Home in Whitney, TX (July 6, 2001) (J-level violation).

<sup>21</sup>HCFA Form 2567 for Nursing Home in Houston, TX (Mar. 5, 2001) (H-level violation).

### C. Nursing Homes with Other Serious Violations

During the review of the complaint investigations, the Special Investigations Division discovered numerous other examples of serious violations at nursing homes that were not included in ‘Nursing Home Compare.’ In each instance, a member of the public viewing ‘Nursing Home Compare’ would have been led to believe that the nursing home had either no violations of federal health standards or at most only minor violations that posed no risk to residents.

For example, all of the following violations occurred at nursing homes that appeared to have no or only minor violations of federal standards according to the data in ‘Nursing Home Compare’ as of December 31, 2001. None of the violations were mentioned in ‘Nursing Home Compare’:

- A North Carolina nursing home failed to provide even basic care to residents. The staff “told residents not to use their call lights” and “instructed residents to soil themselves rather than call for assistance to go to the bathroom.”<sup>22</sup>
- A nursing home in Illinois failed to properly monitor a resident with a history of wandering and failed to effectively respond to a door alarm. As a result, a resident was allowed to exit the home on a February evening and spend the night outside in freezing temperatures as low as 26 degrees Fahrenheit. Staff noticed the resident was missing at 9:00 at night; he was brought to the emergency room by the fire department at 10:15 the next morning, more than 13 hours after the facility noticed he was missing. The resident was admitted with diagnoses of “hypothermia, metabolic acidosis and dehydration.” Two months before, the same resident had also been allowed to leave the facility and “was found wandering the streets by police.”<sup>23</sup>
- Another nursing home in Illinois failed to properly monitor and care for a diabetic resident sent to the hospital several times for high or low blood sugar. On one occasion, the resident called 911 after not receiving necessary attention or care from staff. According to the EMS crew who responded, the resident was “acting lethargic with altered level of consciousness,” and the facility staff “were extremely rude and would not provide information even after multiple requests.” The resident was admitted to the hospital.<sup>24</sup>
- At a nursing home in Texas, a resident was found early in the morning with a swollen

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<sup>22</sup>HCFA Form 2567 for Nursing Home in Plymouth, NC (Mar. 6, 2001) (G-level violation).

<sup>23</sup>HCFA Form 2567 for Nursing Home in Chicago, IL (Feb. 15, 2001) (J-level violation).

<sup>24</sup>HCFA Form 2567 for Nursing Home in Joliet, IL (Aug. 30, 2001) (G-level violation).

right arm covered by skin that was “shiny and discolored.” Despite the condition of the arm deteriorating throughout the day, proper action was not taken until the resident’s son visited her that evening. Finally, “almost 16 hours after the initial observation,” an x-ray was ordered which revealed that the resident had suffered a fracture in her upper right arm. Admission to the hospital revealed that she had also fractured her right hip. A police officer who investigated the incident at the request of the son estimated that the size of the right arm had swollen to “two times the size of the left arm.”<sup>25</sup>

- A nursing home in Iowa repeatedly failed to protect vulnerable residents from falls. One resident was allowed to fall seven times in six months, sustaining multiple injuries. Another resident also fell multiple times due to the failure of the facility to implement proper care and supervision. On one occasion, a resident was found lying in the hallway with “the resident’s head . . . in a pool of red fluid (blood), and red liquid (blood) . . . coming from the resident’s mouth, nose and above the left eyebrow.”<sup>26</sup>

Numerous other violations that injured residents were documented in the complaint investigations, but not reported in ‘Nursing Home Compare.’ These violations all occurred at nursing homes that were described in ‘Nursing Home Compare’ as having either no violations or at most only minor violations that posed no risk to residents. They included violations that caused residents to suffer a fractured leg,<sup>27</sup> a fractured arm,<sup>28</sup> a fractured hip,<sup>29</sup> a fractured wrist,<sup>30</sup> and a fractured skull.<sup>31</sup>

## VII. CONCLUSION

Family members who are concerned about the quality of care in nursing homes rely upon information available from ‘Nursing Home Compare’ to choose a safe nursing home for their loved ones. The HHS website, however, contains incomplete and misleading information. Tens of thousands of violations at nursing homes are excluded from ‘Nursing Home Compare,’ including nearly 60% of the immediate jeopardy violations issued by state inspectors between October 1, 2000, and December 31, 2001. Many nursing homes that appear from ‘Nursing Home

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<sup>25</sup>HCFA Form 2567 for Nursing Home in Houston, TX (Mar. 5, 2001) (J-level violation).

<sup>26</sup>HCFA Form 2567 for Nursing Home in Lake View, IA (Nov. 9, 2000) (G-level violation).

<sup>27</sup>HCFA Form 2567 for Nursing Home in La Marque, TX (Aug. 29, 2001) (G-level violation).

<sup>28</sup>HCFA Form 2567 for Nursing Home in Thorp, WI (July 18, 2001) (G-level violation).

<sup>29</sup>HCFA Form 2567 for Nursing Home in Algona, IA (Mar. 6, 2001) (D-level violation).

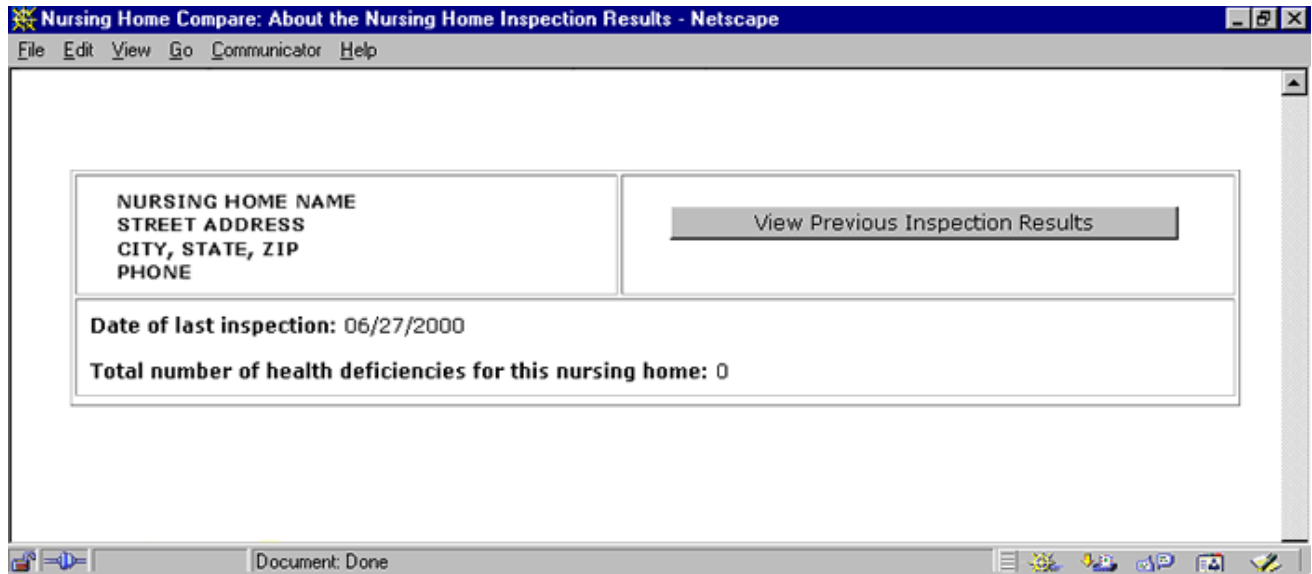
<sup>30</sup>HCFA Form 2567 for Nursing Home in South Holland, IL (Feb. 15, 2001) (G-level violation).

<sup>31</sup>HCFA Form 2567 for Nursing Home in Leeds, MA (Jan. 17, 2001) (G-level violation).



Compare' to be in compliance with federal health standards actually have serious violations that are not reported on 'Nursing Home Compare.'

## Appendix I 'Nursing Home Compare' Display for a Nursing Home with No Violations



## Appendix II

### ‘Nursing Home Compare’ Display for a Nursing Home with Minor Violation

**Nursing Home Compare: About the Nursing Home Inspection Results - Netscape**

File Edit View Go Communicator Help

NURSING HOME NAME STREET ADDRESS CITY, STATE, ZIP PHONE	<input type="button" value="View Previous Inspection Results"/>		
Date of last inspection: 04/27/2001 Total number of health deficiencies for this nursing home: 1			
<b>Environmental Deficiencies</b>			
<b>During the last inspection, inspectors determined that the nursing home failed to:</b>	<b>Date of Correction</b>	<b>Level of Harm</b>	<b>Residents Affected</b> Few->Some-> Many
1. Provide rooms that are big enough for each resident.		1 = Potential for minimal harm Least -> Most <div style="text-align: center; margin-top: 10px;"> <span style="border: 1px solid black; padding: 2px 5px; background-color: #800000; color: white;">1</span> <span style="border: 1px solid black; padding: 2px 5px; background-color: #cccccc;">2</span> <span style="border: 1px solid black; padding: 2px 5px; background-color: #cccccc;">3</span> <span style="border: 1px solid black; padding: 2px 5px; background-color: #cccccc;">4</span> </div>	Some

Document: Done

## Appendix III

### ‘Nursing Home Compare’ Display for a Nursing Home with Serious Violations

**Nursing Home Compare: About the Nursing Home Inspection Results - Netscape**

File Edit View Go Communicator Help

NURSING HOME NAME STREET ADDRESS CITY, STATE, ZIP PHONE	<input type="button" value="View Previous Inspection Results"/>		
<b>Date of last inspection:</b> 11/20/2000 <b>Total number of health deficiencies for this nursing home:</b> 4			
<b>Quality Care Deficiencies</b>			
<b>During the last inspection, inspectors determined that the nursing home failed to:</b>	<b>Date of Correction</b>	<b>Level of Harm</b>	<b>Residents Affected</b> Few->Some-> Many
1. Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.	02/23/2001	3 = Actual harm Least -> Most <div style="text-align: center;"> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4         </div>	Few
2. Make sure each resident is being watched and has assistance devices when needed, to prevent accidents.	02/23/2001	3 = Actual harm Least -> Most <div style="text-align: center;"> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4         </div>	Few
<b>Pharmacy Service Deficiencies</b>			
<b>During the last inspection, inspectors determined that the nursing home failed to:</b>	<b>Date of Correction</b>	<b>Level of Harm</b>	<b>Residents Affected</b> Few->Some-> Many
3. Keep drugs and other similar products locked safely and properly stored.	02/23/2001	2 = Minimal harm or potential for actual harm Least -> Most <div style="text-align: center;"> <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4         </div>	Few
<b>Environmental Deficiencies</b>			
<b>During the last inspection, inspectors determined that the nursing home failed to:</b>	<b>Date of Correction</b>	<b>Level of Harm</b>	<b>Residents Affected</b> Few->Some-> Many
4. Make sure that the nursing home area is free of dangers that cause accidents.	02/23/2001	3 = Actual harm Least -> Most <div style="text-align: center;"> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input checked="" type="checkbox"/> 3 <input type="checkbox"/> 4         </div>	Few

Document: Done