Nursing Home Conditions in Los Angeles County: Many Homes Fail to Meet Federal Standards for Adequate Care

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Prepared for Rep. Henry A. Waxman

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EXECUTIVE SUMMARY

Many families are becoming increasingly concerned about the conditions in nursing homes. Federal law requires that nursing homes "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." But recent studies by the U.S. General Accounting Office and others have indicated that many nursing homes fail to meet federal health and safety standards.

To address these growing concerns, Rep. Henry A. Waxman asked the minority staff of the Committee on Government Reform to investigate the conditions in nursing homes in Los Angeles County. There are 439 nursing homes in Los Angeles County that accept residents covered by Medicaid or Medicare. These homes serve approximately 34,000 residents. This is the first report to evaluate their compliance with federal nursing home standards.

The report finds that there are serious deficiencies in many nursing homes in Los Angeles. Less than 3% of the nursing homes in Los Angeles were in full or substantial compliance with federal standards during their most recent annual inspection. Nineteen percent of the nursing homes in Los Angeles -- almost one out of every five -- had violations that caused actual harm to residents or placed them at risk of death or serious injury.

A. Methodology

Under federal law, the U.S. Department of Health and Human Services contracts with the states to conduct annual inspections of nursing homes. These inspections assess whether nursing homes are meeting federal standards of care, such as preventing residents from developing pressure sores (commonly known as bed sores), providing sanitary living conditions, and protecting residents from accidents. State inspectors are instructed to rate the scope and severity of each violation. There are four general categories of violations: (1) violations that have the potential for only minimal harm; (2) violations that have the potential for more than minimal harm; (3) violations that cause actual harm; and (4) violations that cause actual or potential death or serious injury.

This report is based on an analysis of the most recent annual inspections of the nursing homes in Los Angeles County. These inspections were conducted from November 1997 to August 1999. When a nursing home was reported to have serious violations, the report also examined the results from the prior round of inspections to assess the home's compliance history.

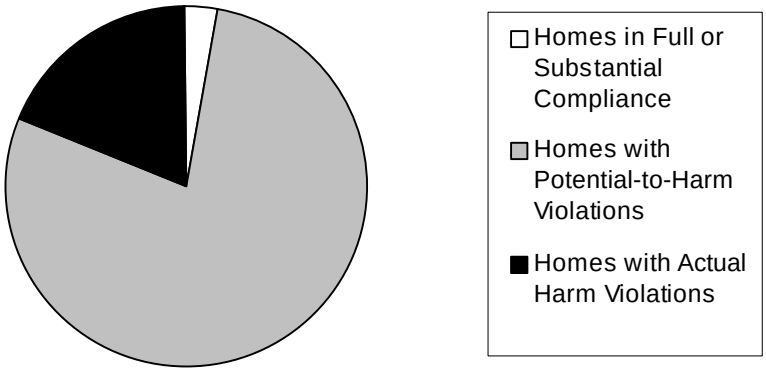
Because this report is based on recent annual inspections, the results are representative of current conditions in nursing homes in Los Angeles County. Conditions in individual homes can change, however. New management or enforcement activities can bring rapid improvement; other changes can lead to sudden deterioration. For this reason, the report should be considered a representative "snapshot" of overall conditions in nursing homes in Los Angeles County, not an analysis of current conditions in any specific home. Conditions could be better -- or worse -- at any individual nursing home today than when the most recent annual inspection was conducted.

B. Findings

Nursing homes in Los Angeles routinely violate federal standards governing quality of care. State inspectors consider a nursing home to be in full compliance with federal standards if no violations are detected during the annual inspection. They will also consider a home to be in "substantial compliance" with federal standards if the violations at the home do not have the potential to cause more than minimal harm. Of the 439 nursing homes in Los Angeles County, only 12 homes -- less than 3% -- were found to be in full or substantial compliance with the federal standards. Over 97% of the nursing homes had at least one violation with the potential to cause more than minimal harm to residents. On average, each of these nursing homes had over nine violations that had the potential to cause harm to residents.

Many nursing homes in Los Angeles have violations that cause actual harm to residents. Of the 439 nursing homes in Los Angeles County, 83 -- or 19% -- had a violation that caused actual harm to nursing home residents or placed them at risk of death or serious injury (see Figure 1). These deficiencies involved serious problems, such as pressure sores, accidents, improper use of medications or restraints, malnutrition, dehydration, and unsanitary conditions. The most frequently cited violations causing actual harm were the failure to prevent and treat pressure sores and the failure to provide residents with appropriate care to prevent accidents. These 83 homes serve over 8,000 residents and are estimated to receive over $180 million each year in federal and state funds.

Figure 1: Compliance Status of Nursing Homes in Los Angeles County



Many nursing homes in Los Angeles have multiple or repeat violations that cause actual harm. Over 10% of the nursing homes in Los Angeles County were cited for more than one violation that caused actual harm to residents or had the potential to cause death or serious injury. Three homes had at least five such violations. Moreover, almost half of the nursing

homes that had violations causing actual harm to residents in the most recent annual inspection also had actual harm violations in the prior annual inspection. Overall, 8% of Los Angeles nursing homes -- nearly one out of twelve -- were cited for actual harm violations in two consecutive annual inspections.

An examination of a random sample of homes with violations that cause actual harm showed serious care problems. Representatives of nursing homes argue that the "overwhelming majority" of nursing homes meet government standards and that many violations causing actual harm are actually trivial in nature. To assess these claims, this report examined in detail the inspection reports from a random sample of homes that had been cited for violations that caused actual harm to residents. The state inspections documented that these violations were for serious care problems, including untreated pressure sores, residents being dropped on the floor, unsanitary conditions, improper dispensing of medication, improper use of restraints, malnutrition, and dehydration. Moreover, the state inspections documented many other serious violations that would be of great concern to families, but were not classified as causing actual harm, indicating that serious deficiencies can exist at nursing homes cited for potential-to-harm violations.

I. GROWING CONCERNS ABOUT NURSING HOME CONDITIONS

Increasingly, Americans are facing difficult decisions about nursing homes. The decision to move a loved one into a nursing home raises very real questions about how the resident will be treated at the nursing home. Will the resident receive proper food and medical treatment? Will the resident be assisted by staff with basic daily activities, such as bathing and dressing? Will the resident be able to live out his or her life with dignity and compassion? These are all legitimate concerns -- and they are becoming more common as America ages.

In 1966, there were 19 million Americans 65 years of age and older.[1] That figure has now risen to 34.6 million Americans, or 13% of the population.[2] In 25 years, the number of Americans aged 65 and older will increase to 62 million, nearly 20% of the population.[3]

This aging population will increase demands for long-term care. There are currently 1.6 million people living in almost 17,000 nursing homes in the United States.[4] The Department of Health and Human Services (HHS) has estimated that 43% of all 65 year olds will use a nursing home at some point during their lives.[5] Of those who do need the services of a nursing home, more than half will require stays of over one year, and over 20% will be in a nursing home for more than five years. The total number of nursing home residents is expected to quadruple from the current 1.6 million to 6.6 million by 2050.[6]

Most nursing homes are run by private for-profit companies. Of the 17,000 nursing homes in the United States, over 11,000 (65%) are operated by for-profit companies. In the 1990s, the nursing home industry witnessed a trend toward consolidation as large national chains

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[1]Health Care Financing Administration, *Medicare Enrollment Trends, 1966-1998* (available at http://www.hcfa.gov/stats/enrltrnd.htm).

[2]U.S. Census Bureau, *Resident Population Estimates of the United States by Age and Sex: April 1, 1990 to August 1, 1999* (Oct. 1, 1999).

[3]U.S. Census Bureau, *Resident Population of the United States: Middle Series Projections, 2015 - 2030, by Age and Sex* (March 1996).

[4]Testimony of Rachel Block, Deputy Director of HCFA's Center for Medicaid, before the Senate Special Committee on Aging (June 30, 1999).

[5]HCFA Report to Congress, *Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System*, §1.1 (July 21, 1998).

[6]American Health Care Association, *Facts and Trends: The Nursing Facility Sourcebook*, 5 (1999).

bought up smaller chains and independent homes. The five largest nursing home chains in the United States operated over 2,000 facilities and had revenues of nearly $14 billion in 1998.[7]

Through the Medicaid and Medicare programs, the federal government is the largest payor of nursing home care. Under the Medicaid program, a jointly funded, federal-state health care program for the needy, all nursing home and related expenses are covered for qualified individuals. Under the Medicare program, a federal program for the elderly and certain disabled persons, skilled nursing services are partially covered for up to 100 days. In 1999, it is projected that federal, state, and local governments will spend $56.1 billion on nursing home care, of which $43.2 billion will come from Medicaid payments ($26.7 billion from the federal government and $16.5 billion from state governments) and $10.8 billion from federal Medicare payments. Private expenditures for nursing home care will be $34.1 billion ($27.9 billion from residents and their families, $4.5 billion from insurance policies, and $1.7 billion from other private funds).[8] The overwhelming majority of nursing homes in the United States receive funding through either the Medicaid program or the Medicare program, or both.

Under federal law, nursing homes that receive Medicaid or Medicare funds must meet federal standards of care. Prior to 1987, these standards were relatively weak: they focused on a home's ability to provide adequate care, rather than on the level of care actually provided. In 1986, a landmark report by the Institute of Medicine found widespread abuses in nursing homes.[9] This report, coupled with national concern over substandard conditions, led Congress to pass comprehensive legislation in 1987 establishing new standards for nursing homes. This law required nursing homes to "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."[10] Rep. Waxman was one of the chief sponsors of the 1987 law.

Implementing regulations were promulgated by HHS in 1990 and 1995. The 1987 law and the implementing regulations limit the use of physical and chemical restraints on nursing home residents. They require nursing homes to prevent pressure sores, which are painful wounds

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[7]Thomas J. Cole, *Awash in Red Ink*, Albuquerque Journal, A1 (Aug. 3, 1999).

[8]All cost projections come from: HCFA, *Nursing Home Care Expenditures and Average Annual Percent Change, by Source of Funds: Selected Calender Years 1970-2008* (available at http://www.hcfa.gov/stats/NHE-Proj/proj1998/tables/table14a.htm).

[9]Committee on Nursing Home Regulation, Institute of Medicine, *Improving the Quality of Care in Nursing Homes* (1986). The IOM report concluded: "individuals who are admitted receive very inadequate -- sometimes shockingly deficient -- care that is likely to hasten the deterioration of their physical, mental, and emotional health. They are also likely to have their rights ignored or violated, and may even be subject to physical abuse." *Id.* at 2-3.

[10]42 U.S.C. 1396r(b)(2).

or bruises caused by pressure or friction that can become infected. They also establish other safety and health standards for nursing homes, such as requiring that residents are properly cleaned and bathed, receive appropriate medical care, and are supervised to prevent falls and accidents. The regulatory requirements are codified at 42 C.F.R. Part 483.

Recently, investigators have begun to examine whether nursing homes are meeting the requirements of the 1987 law and its implementing regulations. The results have not been encouraging. Certain abusive practices documented by the Institute of Medicine in 1986, such as the improper use of physical restraints and anti-psychotic drugs, have been reduced.[11] But health and safety violations appear to be widespread. In a series of reports issued earlier this year, the U.S. General Accounting Office (GAO), an investigative arm of Congress, found that "more than one-fourth of the homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury";[12] that these incidents of actual harm "represented serious care issues ... such as pressure sores, broken bones, severe weight loss, and death";[13] and that "[s]erious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months.[14]

Other researchers have reached similar conclusions. In July 1998, Professor Charlene Harrington of the University of California-San Francisco, a leading nursing home expert, found that the current level of nursing home staffing is "completely inadequate to provide care and supervision."[15] In March 1999, the Inspector General of HHS found an increasing number of serious deficiencies relating to quality of resident care.[16] And in September 1999, the Coalition

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[11]The percent of residents in physical restraints dropped from 38% in 1987 to 15% in 1998; the percent of residents being administered anti-psychotic drugs dropped from 33% to 16% during the same time period. Testimony of Michael Hash, Deputy Administrator of HCFA, before the Senate Special Committee on Aging (July 28, 1998). Despite this progress, the improper use of physical and chemical restraints continues to be a problem at some nursing homes, as documented in part IV of this report.

[12]GAO, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, 3 (March 1999).

[13]GAO, *Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit*, 2 (June 1999).

[14]GAO, *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, 2 (March 1999).

[15]Testimony of Charlene Harrington before the Senate Special Committee on Aging (July 28, 1998).

[16]HHS Office of Inspector General, *Nursing Home Survey and Certification* (Mar. 1999).

to Protect America's Elders concluded: "Every day, thousands of frail elderly Americans are endangered by nursing home abuse and neglect that have reached epidemic proportions."[17]

In light of the growing concern about nursing home conditions, Rep. Waxman asked the minority staff of the Government Reform Committee to investigate the prevalence of health and safety violations in nursing homes in Los Angeles County. This report presents the results of this investigation. It is the first report to comprehensively investigate nursing home conditions in Los Angeles.[18]

II. METHODOLOGY

To assess the conditions in nursing homes in Los Angeles County, this report analyzed two sets of data: (1) the Online Survey, Certification, and Reporting (OSCAR) database maintained by HHS, which compiles the results of nursing home inspections; and (2) actual state inspection reports from a random sample of nursing homes in Los Angeles County.

A. Analysis of the OSCAR Database

Operating through the Health Care Financing Administration (HCFA), which administers the federal Medicaid and Medicare programs, HHS contracts with states to conduct annual inspections of nursing homes. During these inspections, the 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 cited by the inspection team, reported by the states to HCFA, and compiled in the OSCAR database.[19]

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[17]Coalition to Protect America's Elders, *America's Secret Crisis: The Tragedy of Nursing Home Care*, 6 (Sept. 14, 1999).

[18]In recent years, both GAO and the California Advocates for Nursing Home Reform have examined the conditions of nursing homes in California on a statewide basis. *See* GAO, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight* (July 1998); California Advocates for Nursing Home Reform (CANHR), *Status Report on California's Nursing Home Industry* (1998). GAO's study used data from state inspections conducted between July 1995 and February 1998. CANHR's study used data from state inspections conducted between January 1996 and March 1998.

[19]In addition to tracking the violations at each home, the HCFA database compiles the following information about each home: the number of residents and beds; the type of ownership (*e.g.*, for-profit or nonprofit); whether the home accepts patients on Medicare and/or Medicaid; and the characteristics of the resident population (*e.g.*, number of incontinent patients, number of patients in restraints). To provide public access to this information, HCFA maintains a website (http://www.medicare.gov/nursing/home.asp) where the public can obtain data about individual nursing homes.

HCFA has established a ranking system in order to identify the violations that pose the greatest risk to patients. This ranking system is used by state inspectors, and the rankings are included in the OSCAR database. The rankings are based on the severity (degree of actual harm to patients) and the scope (the number of patients affected) of the violation. As shown in Table 1, each violation is given a letter rank, A to L, with A being the least serious (an isolated violation that poses minimal risks to patients) and L being the most serious (a widespread violation that causes or has the potential to cause death or serious injury). Homes with violations in categories A, B, or C are considered in "substantial compliance" with the law. Homes with violations in categories D, E, or F have the potential to cause "more than minimal harm" to residents. Homes with violations in categories G, H, or I are causing "actual harm" to residents. And homes with violations in categories J, K, or L are causing (or have the potential to cause) death or serious injury to residents.

Table 1: HCFA's Scope and Severity Grid for Nursing Home Violations

Severity of Deficiency	**Scope of Deficiency**		
	Isolated	*Pattern of Harm*	*Widespread Harm*
Potential for Minimal Harm	A	B	C
Potential for More Than Minimal Harm	D	E	F
Actual Harm	G	H	I
Actual or Potential for Death/Serious Injury	J	K	L

This report analyzed the results, as reported in the OSCAR database, of the most recent state inspections of each nursing home in Los Angeles County. These inspections were conducted between November 1997 and August 1999. Following the approach used by GAO in its reports on nursing home conditions, this report focused primarily on violations ranked in category G or above. These are the violations that cause actual harm to residents or have the potential to cause death or serious injury.

In cases where nursing homes were reported to have violations causing actual harm to residents in the most recent inspection, the report also analyzed the results of the previous inspection of the nursing home. This analysis was undertaken to assess whether there was a pattern of noncompliance at nursing homes in Los Angeles County.

B. Analysis of State Inspection Reports

In addition to analyzing the data in the OSCAR database, this report analyzed a random sample of the actual inspection reports prepared by state investigators surveying nursing homes in Los Angeles County. These inspection reports, prepared on a HCFA form called "Form 2567," contain the inspectors' documentation of the conditions at the nursing home.

The minority staff selected the forms for review using a two-step process. First, the staff prepared a list of all nursing homes in Los Angeles County cited for violations at the actual harm

level or above during their most recent state inspection as of June 1999. Second, the staff randomly selected 30 of these homes for an in-depth review. For each home selected, the staff obtained the most recent state inspection report from the Los Angeles County Department of Health Services. These reports were then reviewed to assess the severity of the violations documented by the state inspectors.

C. Interpretation of Results

The results presented in this report are representative of current conditions in nursing homes in Los Angeles County. In the case of any individual home, however, current conditions may differ from those documented in the most recent annual inspection report, especially if the report is more than few months old. Nursing home conditions can change over time. New management or enforcement activities can rapidly improve conditions; other changes can lead to sudden deterioration. According to GAO, many nursing homes with serious deficiencies exhibit a "yo-yo pattern" of noncompliance and compliance: after a home is cited for deficiencies, it briefly comes into compliance to avoid fines or other sanctions, only to slip into noncompliance after the threat of sanctions is removed.[20]

For this reason, this report should be considered a representative "snapshot" of nursing home conditions in Los Angeles County. It is not intended to be -- and should not be interpreted as -- an analysis of current conditions in any individual nursing home.

III. NURSING HOME CONDITIONS IN LOS ANGELES COUNTY

There are 439 nursing homes in Los Angeles County that accept residents whose care is paid for by Medicaid or Medicare. These nursing homes have 40,820 beds that were occupied by 34,140 residents during the most recent round of inspections. The majority of these residents, 23,219, rely on Medicaid to pay for their nursing home care. Medicare pays the cost of care for 2,916 residents. Over three-quarters of the 439 nursing homes in Los Angeles (78%) are private for-profit nursing homes.

The conditions in these nursing homes often fall substantially below federal standards. Many residents are not receiving the care that their families expect and that federal law requires.

A. Prevalence of Violations

Few nursing homes in Los Angeles were found to be in full or substantial compliance with federal standards of care by the state inspections. Only one of the 439 nursing homes -- less

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[20]GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 12, at 12-14 ("This yo-yo pattern of compliance and noncompliance could be found even among homes that were terminated from Medicare, Medicaid, or both").

than 1% -- met all federal requirements during the inspections.[21] Only 11 of the 439 nursing homes were in substantial compliance with federal standards, meaning that they had no deficiencies that posed more than a minimal risk of harm.

The rest of the nursing homes in Los Angeles -- 427 out of 439 -- had at least one violation that had the potential to cause more than minimal harm to their residents. Eighty-three homes had violations that caused actual harm or had the potential to cause death or serious injury. These 83 homes served a total of 8,140 residents. Table 2 summarizes these results.

Table 2: Nursing Homes in Los Angeles County Have Numerous Violations that Place Residents at Risk

Most Severe Violation Cited by Inspectors	Number of Homes	Percent of Homes	Number of Residents
Complete Compliance (No Violations)	1	0.2%	6
Substantial Compliance (Risk of Minimal Harm)	11	2.5%	566
Potential for More than Minimal Harm	344	78%	25,428
Actual Harm to Residents	79	18%	7,686
Actual or Potential Death/Serious Injury	4	1%	454

Many nursing homes had multiple violations. During the most recent annual inspections, state inspectors found a total of 3,980 violations that had the potential to cause more than minimal harm or worse. This is an average of 9.3 such violations per home cited.

B. Prevalence of Violations Causing Actual Harm to Residents

According to the GAO, some of the greatest safety concerns are posed by nursing homes with violations that cause actual harm to residents or have the potential to cause death or serious injury. These are homes with violations ranked at G-level or higher. As shown in table 2, 79 nursing homes in Los Angeles had violations that caused actual harm to residents. Another four homes had violations that caused actual death or serious injury or had the potential to do so. In total, 19% of the nursing homes in Los Angeles -- almost one out of every five -- caused actual harm to residents or had the potential to cause death or serious injury. These homes are estimated to receive over $180 million in federal and state funds each year.[22]

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[21]According to the OSCAR database, there are two homes that were not cited for any violations during their most recent inspection. However, the California Department of Health Services advised the minority staff that one of these homes was actually cited for violations but that the data was incorrectly recorded in the OSCAR database.

[22]In 1997, the California Medicaid program spent over $2 billion in federal and state funds for approximately 70,000 California nursing home residents on Medicaid. Approximately 8.5% of these residents were in the 83 Los Angeles County nursing homes with an actual harm

Many nursing homes had multiple violations that caused actual harms to residents. Forty-five nursing homes (10%) had two or more violations that caused actual harm to residents; 18 homes (4%) had three or more violations that caused actual harm to residents, and 10 homes (2%) had four or more violations that caused actual harm to residents. There were three homes that had five or more actual harm violations.

C. Most Frequently Cited Violations Causing Actual Harm

In total, state inspectors cited Los Angeles nursing homes for 160 violations causing actual harm to residents or having the potential to cause death or serious injury. These 160 violations fell into 38 different deficiency areas.

The most frequently cited violation causing actual harm involved pressure sores. Pressure sores are open sores or bruises on the skin (usually on the hips, heels, buttocks, or bony areas) which result from friction or pressure on the skin. Not only are pressure sores painful, but they can lead to infection, increased debilitation, damage to muscle and bone, and even death. According to nursing home experts, good nursing care can often prevent pressure sores through simple precautions, such as regular cleanings, application of ointments and dressings, and frequently turning of the resident to relieve pressure on one part of the body. Despite the availability of these precautions, 24 nursing homes in Los Angeles were cited for violations of the federal requirement that residents not develop pressure sores and that residents with pressure sores "receive[] necessary treatment and services to promote healing, prevent infection and prevent new sores from developing."[23]

The second most common violation at the actual harm level involved accidents to residents, such as falls that cause broken bones or head lacerations. Nineteen nursing homes in Los Angeles were cited for violations of the federal requirement that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents."[24]

Other common violations causing actual harm or having the potential to cause death or serious injury are the failure to provide each resident with the care and services necessary to maintain the highest achievable level of well being (18 homes cited) and the failure to provide proper treatment and services for residents with limited range of motion, such as wheelchair- or bed-bound residents (9 homes cited). Although these are general categories, they can include

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violation. Assuming that reimbursement rates for these patients were the same as reimbursement rates for other patients in the state, Medicaid spent approximately $180 million in these 83 homes. Since this figure does not include funds provided through the federal Medicare program, the actual amount of federal and state funds received by these homes is likely to be higher.

[23]42 C.F.R. §483.25(c).

[24]42 C.F.R. §483.25(h).

serious violations such as failure to provide appropriate medical treatment, failure to assist residents with eating, and failure to clean and bathe residents. Table 3 summarizes these results.

Table 3: Most Common Actual Harm Violations in Los Angeles County Nursing Homes

Violation	Number of Homes Cited	GAO Description of Health Consequences
Failure to provide each resident with proper treatment to prevent new pressure sores or heal old ones	24	"Without proper care, complications of pressure sores can occur and include pain, infection, increased debilitation, and skin loss with extensive destruction or damage to muscle and bone. The severity can range from skin redness to large wounds that can expose skin tissue and bone."
Failure to provide supervision or assistance devices to prevent accidents	19	"Without appropriate supervision and accident prevention devices, such as alarm devices or external hip protectors, accidental injury may be more likely to occur, especially for bed-bound residents, who are at the highest risk for falls because they may try to get out of bed on their own and fall, which often results in serious injury, such as hip fracture."
Failure to provide each resident with the care and services necessary to maintain the highest achievable level of well being	18	"The quality of care that residents receive is largely dependent on assessment of their needs and developing and following the plan of care developed to meet these needs."
Failure to provide proper treatment and services for residents with limited range of motion, such as wheelchair- or bed-bound residents	9	"Lack of physical exercise can lead to a loss of function or range of motion in the fingers, wrists, elbows, shoulders, hips, knees, and ankles. A decline in a resident's physical range of motion can result in arm and leg contractures and further pain, debilitation, and immobility."

Several nursing homes in Los Angeles County also caused actual harm to residents by failing to keep patients free of unnecessary restraints (6 homes cited) and subjecting residents to verbal, sexual, physical and mental abuse, or seclusion (4 homes cited).

D. Nursing Homes with a History of Noncompliance

Many of the nursing homes found to be causing actual harm to residents in the most recent state inspections have a history of serious noncompliance. Of the 83 nursing homes in the most recent inspections with violations at the actual harm level or higher, 36 homes were also found to be causing actual harm or worse in the immediately preceding inspection. Overall, 8% of the nursing homes in Los Angeles -- nearly one out of every twelve -- were cited for a

violation that caused actual harm or had the potential for death or serious injury in two consecutive annual inspections.

E. Potential for Underreporting of Violations

The minority staff's analysis of the prevalence of nursing home violations was based on the data reported to HCFA in the OSCAR database. According to GAO, even though this database is "generally recognize[d] ... as reliable," it may "understate the extent of deficiencies."[25] One problem, according to GAO, was that "homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations."[26] A second problem was that when GAO inspectors accompanied state inspection teams, they found that the state inspectors sometimes missed significant violations, such as unexplained weight loss by residents and failure to prevent pressure sores.[27] Consequently, it is very likely that the prevalence of violations causing potential or actual harm may be higher than what is reported in this study.

IV. DOCUMENTATION OF VIOLATIONS IN THE INSPECTION REPORTS

Representatives for the nursing home industry have alleged that the actual harm violations cited by state inspectors are often insignificant. The American Health Care Association (AHCA), which represents for-profit nursing homes, has stated that the "overwhelming majority of nursing facilities in America meet or exceed government standards for quality."[28] AHCA also claims that deficiencies cited by inspectors are often "technical violations posing no jeopardy to residents" and that the current inspection system "has all the trademarks of a bureaucratic government program out of control."[29] As an example of such a technical violation, AHCA has claimed that the cancellation of a painting class would constitute

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[25]*Id.* at 30.

[26]GAO, *California Nursing Homes, supra* note 18, at 4.

[27]*Id.* at 18-19. Federal inspectors also independently inspect a select number of nursing homes after states have completed their inspections. A recent GAO report found that in 69% of the instances in which this follow-up federal inspection was conducted, federal inspectors found more serious deficiencies than the state inspectors had found. GAO, *Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality*, 9 (Nov. 1999).

[28]Statement of Linda Keegan, Vice President, AHCA, regarding Senate Select Committee on Aging Forum: "Consumers Assess the Nursing Home Initiatives" (Sept. 23, 1999).

[29]AHCA Press Release, *AHCA Responds to Release of General Accounting Office Study on Enforcement* (March 18, 1999).

a serious deficiency.[30]

At the national level, these assertions have proven to be erroneous. In response to AHCA's criticisms, GAO recently undertook a review of 201 random actual harm violations from 107 nursing homes around the country. GAO found that nearly all of these deficiencies posed a serious harm to residents. Of the 107 homes surveyed, 98% were found to have a deficiency that caused actual harm, including "pressure sores, broken bones, severe weight loss, burns, and death."[31] GAO found that many of the deficiencies affected multiple residents.[32]

This report undertook a similar analysis at the local level. To assess the severity of violations at Los Angeles nursing homes, the minority staff examined the state inspection forms for 30 randomly selected nursing homes in Los Angeles County with a deficiency of G-level or above. These survey forms contained numerous examples of mistreatment and neglect of residents. The violations documented in the reports included failure to prevent or properly treat pressure sores, failure to prevent serious accidents, failure to properly clean and care for residents, failure to provide proper medical care, improper use of physical and chemical restraints, improper nutrition and hydration, and inadequate staffing.

One of the most disturbing findings from the review of the inspection reports was that the serious violations were not limited to violations cited at the G-level and above. To the contrary, many of the violations classified as having a "potential for more than minimal harm" (violations at the D, E, or F levels) involved conditions and mistreatment that would be regarded by most families of residents as unacceptable. These potential-to-harm violations included serious violations such as dropping residents, unsanitary conditions, failure to administer pain medications, improper chemical restraints, and inadequate staffing. The severity of these violations indicates that serious deficiencies can exist even at nursing homes that are not cited for actual harm violations.

The following discussion summarizes examples of the potential-to-harm and actual harm violations documented in the inspection reports of the 30 randomly selected homes.

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[30]Letter from Sen. Charles E. Grassley to William Scanlon, GAO, 1, May 27, 1999.

[31]GAO, *Nursing Homes: Proposal to Enhance Oversight, supra* note 13, at 2. A subsequent GAO study in September 1999 examined several examples provided by AHCA of serious deficiencies cited by state inspectors that AHCA asserted were of questionable merit. For those deficiencies which it had sufficient facts to analyze, GAO concluded that the regulatory actions taken against these homes were merited. Releasing these GAO findings, Senator Grassley, the chairman of the Senate Special Committee on Aging, stated: "The nursing home industry challenged the credibility of nursing home inspectors. The nursing home industry, after this challenge, lost." Congressional Record, S10745 (Sept. 13, 1999).

[32]GAO, *Nursing Homes: Proposal to Enhance Oversight, supra* note 13, at 6.

A. Failure to Prevent or Properly Treat Pressure Sores

Many violations documented in the inspection reports involved the improper prevention and treatment of pressure sores. This is a serious violation because pressure sores, if untreated, can lead to infection, muscle and bone damage, and even death.

At one home, the state inspector interviewed a resident with a stage III pressure sore, which is the second most severe type of sore. According to the treatment plan, the resident was supposed to be turned frequently to relieve pressure on the sore and prevent the development of new sores. The state inspector, however, observed the resident lying in the same position for over three hours. According to the report, when a nurse finally turned the resident to treat the pressure sore, the resident was:

> observed lying on double pads that were wet with urine and feces, and soaked through all of the bed linen. An indwelling catheter was in place, smeared with feces, and leaking. . . . A strong odor of urine and feces was present, coming from the resident's body.

The resident told the state inspector that her linen had not been changed in ten hours. A nurse interviewed by the state inspector admitted to the inspector that the facility was not taking the proper measures to "promote healing of the . . . pressure sore, prevent infection, and to keep new sores from developing."[33]

At another nursing home, the state inspectors reviewed the conditions of ten randomly selected residents. They found that four of these residents had developed pressure sores while in the facility. The inspectors also found that the home was not taking proper steps to prevent and treat the sores, such as turning the residents every two hours and applying proper dressing to the sores.[34]

At the nursing home with the worst pressure sore problems in the sample examined by the minority staff, 62 out of a total of 112 residents had pressure sores. Of the 62 residents, 27 of them had developed sores in the previous month. A total of 147 treatments were required on the sores, yet the home had only one licensed nurse to provide all 147 pressure sore treatments.[35]

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[33]HCFA Form 2567 for Nursing Home in Long Beach (Nov. 24, 1998) (G-level violation).

[34]HCFA Form 2567 for Nursing Home in Lancaster (Jan. 13, 1998) (H-level violation) (this home has subsequently closed).

[35]HCFA Form 2567 for Nursing Home in Chatsworth (Jan. 29, 1999) (G-level violation).

B. Failure to Prevent Falls and Accidents

Preventable falls and accidents were another common type of violation documented in the state inspection reports. In one case, a resident with both legs amputated was dropped on the floor while being transferred by a nurse aide from a wheelchair to a bed. The resident had to be admitted to the hospital for a fractured thighbone. When interviewed by inspectors, the aide conceded that she should have asked another nurse to assist her in transferring the patient.[36]

In another case, a nurse attempted to perform tracheostomy care on a resident without the assistance of another nurse, contrary to facility policy. During the procedure, the resident, who was known to have a tendency to roll onto his side, rolled off the bed and landed on the floor at the nurse's feet.[37]

Other avoidable falls and accidents described in the reports resulted in head lacerations requiring sutures and hospitalization.[38]

C. Failure to Properly Clean and Care for Residents

Federal standards require that nursing homes provide residents with "the necessary services to maintain good nutrition, grooming, and personal and oral hygiene."[39] These standards reflect the expectations of families that residents will be properly cared for and cleaned. The inspection reports documented, however, that even this basic level of care was not being provided in many nursing homes in Los Angeles.

The inspection reports contained numerous instances of improper care and cleaning of residents. For example:

> A state inspector observed a nurse assistant using a washcloth and water soiled with feces to give a "bed bath" to a resident.[40]

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[36]HCFA Form 2567 for Nursing Home in Pasadena (Sept. 24, 1998) (G-level violation).

[37]HCFA Form 2567 for Nursing Home in Sun Valley (July 5, 1999) (D-level violation).

[38]HCFA Form 2567 for Nursing Home in Torrance (Dec. 29, 1998) (G-level violation); HCFA Form 2567 for Nursing Home in Los Angeles (Nov. 17, 1998) (D-level violation) (this home has subsequently undergone a change in ownership).

[39]42 C.F.R. §483.25(a)(3).

[40]HCFA Form 2567 for Nursing Home in Los Angeles (Aug. 13, 1999) (D-level violation).

A resident was observed by state inspectors with vomit on her neck and shoulders, as well as on the floor. No staff member was attending to the resident. In fact, a nurse aide walking by the resident offered no assistance, despite the fact that state inspectors were present.[41]

Incontinent residents complained to a state inspector of being left in soiled diapers for long periods of time. One resident told inspectors, "I should not have to beg the nurses to change me."[42]

Residents who were completely dependent on staff for assistance with daily activities went a month without being showered. One resident told inspectors, "[W]hat is it going to take to get a shower around here? I have told them I want a shower, but I just don't get it."[43]

A resident who was completely dependent on staff for help in performing daily activities told a state inspector that no one had brushed her teeth for four days.[44]

State inspectors detected a "strong urine odor" throughout one nursing home and found three large bowel movements on the outside patio.[45]

D. Failure to Provide Proper Medical Care

In addition to failing to provide proper basic care for residents, the nursing homes in the sample also frequently failed to provide proper medical care. Doctor's instructions were ignored; necessary medications were not administered; and vital medical devices, such as urinary catheters and breathing tubes, were not properly cleaned and maintained. For example:

State inspectors observed a resident "crying and grimacing" in pain on several occasions. The physician's orders said she was to be monitored for signs of pain such as "facial grimaces" and "sounds" and administered morphine sulfate to ease the pain. The state inspectors found, however, that no pain medication had been administered for the

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[41]HCFA Form 2567 for Nursing Home in Chatsworth (Jan. 29, 1999) (E-level violation).

[42]HCFA Form 2567 for Nursing Home in Hawthorne (Dec. 20, 1998) (E-level violation).

[43]HCFA Form 2567 for Nursing Home in Long Beach (June 28, 1999) (E-level violation).

[44]HCFA Form 2567 for Nursing Home in N. Hollywood (Dec. 21, 1998) (D-level violation).

[45]HCFA Form 2567 for Nursing Home in Baldwin Park (May 19, 1999) (D-level violation).

previous two months.[46]

State inspectors observed a resident with brown drainage coming out of his scalp and staining his pillow. Upon checking the resident's records, the inspectors learned that a doctor had ordered the application of an antibiotic ointment to treat the injury, but that this order had been ignored and the resident had not received treatment for many weeks.[47]

At one home, a resident with acute malignant hypertension did not receive medication for at least a week; a second resident with an abdominal aneurysm did not receive medication for at least a week; and a third resident with a thyroid problem and hypertension did not receive medication for at least five days.[48]

State inspectors observed that a resident whose breathing was assisted by a tracheostomy tube was making "gurgling noises" and had "large amounts of light brown mucous secretions hanging out of her trach tube." Even though the gurgling sound could be heard at the nurses' station, where two licensed nurses were talking with each other, the state inspectors reported that "no one made an attempt to find out where the gurgling sound was coming from."[49]

E. Improper Use of Physical and Chemical Restraints

One of the major objectives of the 1987 nursing home law was to end the improper use of physical and chemical restraints. Although progress has been made in this area, the inspection reports documented that improper restraints continue to be a problem. For instance, a resident who was able to walk was improperly strapped into a wheelchair. When the state inspectors visited the nursing home, they repeatedly saw the resident hobbling around with the wheelchair still strapped to him.[50]

Other violations involved facilities inappropriately using medication to restrain patients.

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[46]HCFA Form 2567 for Nursing Home in Los Angeles (Aug. 13, 1999) (D-level violation).

[47]HCFA Form 2567 for Nursing Home in Pomona (June 3, 1999) (G-level violation).

[48]HCFA Form 2567 for Nursing Home in Lomita (Aug. 31, 1998) (H-level violation) (this home has subsequently closed).

[49]HCFA Form 2567 for Nursing Home in Los Angeles (June 11, 1999) (D-level violation).

[50]HCFA Form 2567 for Nursing Home in Baldwin Park (May 19, 1999) (G-level violation).

At one facility, two residents were prescribed an anti-psychotic drug: one for saying that the staff was trying to "poison" her; another for saying "people are talking bad things about her." In neither case was there any evidence that the facility had tried less drastic measures before using drugs.[51]

In another facility, a resident was given an anti-anxiety drug in order to prevent the resident from laughing.[52] At yet another nursing home, a resident was kept on a "sedating medication" even though a psychiatrist had recommended that the resident's use of the drug be decreased.[53]

F. Inadequate Nutrition and Hydration

Failure to provide proper nutrition and hydration was the reason for other violations. For example:

> A blind 92 year old resident lost 10% of her weight in nine months. Nothing was done to determine why she had lost the weight. During the inspection, state inspectors observed her during two breakfasts "tapping her spoon on her plate to find the remainder of the food." Although the resident told inspectors that she "gets frustrated when she can't find her food and doesn't want to finish," a nurse aide removed the breakfast tray without offering to assist the resident with eating.[54]
>
> A resident was recorded during various times in 1997 as weighing between 170 and 184 pounds, within the normal range for his height. Nevertheless, the resident was put on a weight-reduction diet. By March 1999, his weight had dropped to 148 pounds, well below his ideal body weight. Finally, the facility's dietician recommended that the resident be put on a normal diet. This change was not implemented for another two months, which, according to the inspectors, "compromised his nutritional status."[55]
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> Laboratory tests indicated that a resident with swallowing problems and a feeding tube

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[51]HCFA Form 2567 for Nursing Home in Long Beach (Nov. 24, 1998) (D-level violation).

[52]HCFA Form 2567 for Nursing Home in Lake View Terrace (Jan. 13, 1998) (E-level violation).

[53]HCFA Form 2567 for Nursing Home in Los Angeles (Nov. 17, 1998) (D-level violation) (this home has subsequently undergone a change in ownership).

[54]HCFA Form 2567 for Nursing Home in Torrance (Sept. 15, 1998) (G-level violation).

[55]HCFA Form 2567 for Nursing Home in Pomona (June 3, 1999) (D-level violation).

had "clinical signs of possible insufficient fluid intake." However, the nursing home did no follow-up on this diagnosis for two months. As a result, when a physician finally visited the resident two months later, the resident had to be sent to an acute care facility for dehydration and a urinary tract infection. Even after the resident was returned to the nursing home, no treatment plan was implemented to ensure that the resident received adequate fluids.[56]

G. Other Violations

Some violations, while not life-threatening, provided troubling evidence of the callous attitude sometimes displayed towards residents. Inspectors asked three employees at one home what they would do if they saw a resident on fire. Not only were all three unfamiliar with the facility's emergency procedures, one said she would simply "close the door."[57]

At another facility, inspectors saw an employee storing emergency drinking water in old bleach and fabric softener containers, even though the manufacturer's label clearly stated that the containers were not to be reused. Actual bottles of bleach and fabric softener were stored next to the drinking water. When confronted by the inspectors about this practice, the employee responded, "Do you know how much bottled water costs?"[58]

H. Inadequate Staffing

An underlying cause of many of the violations was inadequate staffing. At one home, for example, three nurses aides were responsible for 42 residents, all of whom were totally dependent on staff or required extensive assistance.[59]

At another home, two licensed nurses and two nurse aides were assigned to care for 72 residents, most of whom were partially or completely dependent on staff for eating, bathing, dressing, and using the bathroom. As a result, showers and baths were not provided on a regular basis, and residents frequently smelled of urine. Meals were also left at the bedsides of some residents requiring complete assistance with eating.[60]

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[56]HCFA Form 2567 for Nursing Home in Long Beach (Nov. 24, 1998) (G-level violation).

[57]HCFA Form 2567 for Nursing Home in Los Angeles (May 9, 1999) (D-level violation) (this home has an ownership change pending).

[58]HCFA Form 2567 for Nursing Home in Pasadena (Sept. 24, 1998) (E-level violation).

[59]HCFA Form 2567 for Nursing Home in Chatsworth (Jan. 29, 1999) (E-level violation).

[60]HCFA Form 2567 for Nursing Home in Hawthorne (Dec. 20, 1998) (E-level violation).

V. CONCLUSION

The 1987 nursing home law was intended to stop abuses in nursing homes by establishing stringent federal standards of care. Although the law and its implementing regulations require appropriate standards of care, compliance by nursing homes in Los Angeles County has been poor. This report reviewed the OSCAR database and a random sample of actual state inspection reports. The same conclusion emerges from both analyses: many nursing homes in Los Angeles are failing to provide the care that the law requires and that families expect.