Nursing Home Conditions in the 1st Congressional District of Missouri: Many Homes Fail to Meet Federal Standards for Adequate Care

---

Prepared for Rep. Wm. Lacy Clay

Minority Staff
Special Investigations Division
Committee on Government Reform
U.S. House of Representatives

November 19, 2001

Table of Contents

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. Wm. Lacy Clay asked the Special Investigations Division of the minority staff of the Committee on Government Reform to investigate the conditions in nursing homes in his district, the 1st Congressional District of Missouri, which includes part of St. Louis. There are 30 nursing homes in Rep. Clay's district that accept residents covered by Medicaid or Medicare. These homes serve over 2,600 residents. This is the first congressional report to evaluate their compliance with federal nursing home standards.

The report finds that there are serious deficiencies in the nursing homes in Rep. Clay's district. All 30 nursing homes in the district violated federal health and safety standards during recent state inspections. Moreover, one-half of the nursing homes had violations that caused actual harm to residents or had the potential to cause 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 and to investigate nursing home complaints. These inspections and investigations 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.

This report is based on an analysis of these state inspections and investigations. It examines recent annual inspections of nursing homes in Rep. Clay's district. These inspections were conducted from March 2000 to July 2001. In addition, the report examines the results of any complaint investigations conducted during this time period.

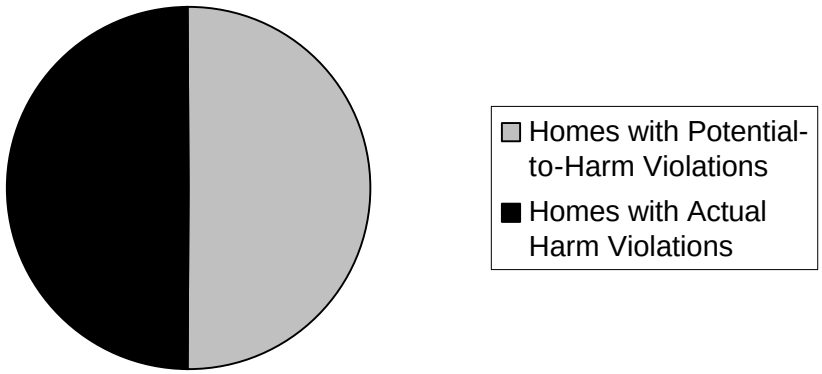
Because this report is based on recent state inspections, the results are representative of current nursing home conditions in the district as a whole. However, conditions in individual homes can change. New management or enforcement activities can bring rapid improvement; other changes can lead to sudden deterioration. For this reason, the report should be considered a representative "snapshot" of overall conditions in nursing homes in Rep. Clay's district, 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 facility was last inspected.

B. Findings

Every nursing home in Rep. Clay's district violated federal standards governing quality of care. State inspectors consider a nursing home to be in full compliance with federal health and safety standards if no violations are detected during the inspection. They will 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 30 nursing homes in Rep. Clay's district, none was found to be in full or substantial compliance with federal standards. All 30 nursing homes had at least one violation with the potential to cause more than minimal harm to residents or worse. On average, each of these 30 nursing homes had 13 violations of federal quality of care requirements.

Many nursing homes in Rep. Clay's district had violations that caused actual harm to residents. Of the 30 nursing homes in Rep. Clay's district, 15 homes -- one-half of all facilities -- had a violation that caused actual harm to nursing home residents or had the potential to cause death or serious injury (see Figure 1). These deficiencies involved serious care problems. Frequently cited violations causing actual harm involved preventable accidents and improper medical care. The 15 homes with actual harm violations serve 1,595 residents and are estimated to receive over $23 million each year in federal and state funds.

Figure 1: Compliance Status of Nursing Homes in the 1st Congressional District



An examination of the homes with significant violations 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, inspection reports from 16 homes that were cited for multiple, serious violations were examined in detail. These inspection reports documented that the actual harm violations cited by state inspectors were for neglect and mistreatment of residents. Moreover, the inspection reports 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 34.9 million Americans, 13% of the population.[2] By 2030, the number of Americans aged 65 and older will increase to 70.3 million, 20% of the population.[3]

This aging population will increase demands for long-term care. There are currently 1.5 million people living in 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

---

[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 July 1, 1999, with Short-Term Projections to November 1, 2000* (Jan. 2, 2001).

[3]U.S. Census Bureau, *Projections of the Total Resident Population by 5-Year Age Groups, Race, and Hispanic Origin with Special Age Categories: Middle Series 2025-2045* (Jan. 13, 2000).

[4]American Health Care Association, *Facts and Trends: The Nursing Facility Sourcebook*, vii (2001).

[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*, vii (2001).

1990s, the nursing home industry witnessed a trend toward consolidation as large national chains bought up smaller chains and independent homes. As of December 1999, the six largest nursing home chains in the United States operated 2,241 facilities with over 266,000 beds.[7]

Through the Medicaid and Medicare programs, the federal government is the largest payer 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 2001, it is projected that federal, state, and local governments will spend $61.2 billion on nursing home care, of which $46.8 billion will come from Medicaid payments ($29 billion from the federal government and $17.8 billion from state governments) and $12.1 billion from federal Medicare payments. Private expenditures for nursing home care are estimated to be $38.1 billion ($31 billion from residents and their families, $5.2 billion from insurance policies, and $1.9 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 requires nursing homes to "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."[10]

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

---

[7]Aventis Pharmaceuticals, Managed Care Digest Series 2000 (available at http://www.managedcaredigest.com/is2000/is2000.html).

[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: "[I]ndividuals 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).

residents. They require nursing homes to prevent pressure sores, which are painful wounds 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 recent reports, 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 the quality of resident care.[16] And in July 2000, HHS reported that

---

[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).

[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).

the quality of care in many nursing homes may be "seriously impaired" by inadequate staffing.[17]

In light of the growing concern about nursing home conditions, Rep. Wm. Lacy Clay asked the Special Investigations Division of the minority staff of the Government Reform Committee to investigate the prevalence of health and safety violations in nursing homes in his district. Rep. Clay represents the 1st Congressional District of Missouri, which includes part of St. Louis. This report presents the results of this investigation. It is the first congressional report to comprehensively investigate nursing home conditions in Rep. Clay's district.

II. METHODOLOGY

To assess the conditions in nursing homes in Rep. Clay's district, this report analyzed three sets of data: (1) the Online Survey, Certification, and Reporting (OSCAR) database maintained by HHS, which compiles the results of nursing home inspections; (2) the nursing home complaint database maintained by HHS, which contains the results of state complaint investigations; and (3) state inspection reports from 16 nursing homes in Rep. Clay's district.

A. Determination of Compliance Status

Data on the compliance status of nursing homes in Rep. Clay's district comes from the OSCAR database and the complaint database. These databases are compiled by the Center for Medicare and Medicaid Services (CMS), a division of HHS.[18] CMS contracts with states to conduct annual inspections of nursing homes and to respond to nursing home complaints. During these inspections and investigations, 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 CMS, and compiled in the OSCAR and complaint databases.[19]

The OSCAR and complaint databases 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

---

[17]HHS, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, E.S.-5 (Summer 2000).

[18]Until recently, CMS was known as the Health Care Financing Administration (HCFA).

[19]In addition to tracking the violations at each home, the OSCAR 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 residents on Medicare and/or Medicaid; and the characteristics of the resident population (*e.g.*, number of incontinent residents, number of residents in restraints). To provide public access to this information, CMS maintains a website (http://www.medicare.gov/nhcompare/home.asp) where the public can obtain data about individual nursing homes.

of actual harm to residents) and the scope (the number of residents 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 residents) 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 to be 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

To assess the compliance status of nursing homes in Rep. Clay's district, this report analyzed the OSCAR database to determine the results of recent annual inspections of each nursing home in the district. These inspections were conducted between March 2000 and July 2001. In addition, the report analyzed the complaint database to determine the results of any nursing home complaint investigations that were conducted during this same time period. 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.

B. Analysis of State Inspection Reports

In addition to analyzing the data in the OSCAR and complaint databases, this report analyzed a sample of the actual inspection reports prepared by state inspectors of nursing homes in the 1st Congressional District. These inspection reports, prepared on a CMS form called "Form 2567," contain the inspectors' documentation of the conditions at the nursing home.

The Special Investigations Division selected for review the inspection reports from 16 nursing homes that were cited for multiple, serious violations. For each of these homes, a recent state inspection report was obtained from the Missouri Department of Social Services, Division of Aging. For several of these nursing homes, the Special Investigations Division also obtained reports of other inspections and investigations conducted by the Missouri Division of Aging over the past two years. 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 Rep. Clay's district as a whole. In the case of any individual home, however, current conditions may differ from those documented in recent inspection reports, especially if the report is more than a 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 the 1st Congressional District. It is not intended to be -- and should not be interpreted as -- an analysis of current conditions in any individual nursing home.

The report also should not be used to compare violation rates in nursing homes in Rep. Clay's district with violation rates in other states. Data regarding violation rates comes from state inspections that can vary considerably from state to state in their thoroughness and ability to detect violations. According to GAO, "[c]onsiderable inter-state variation still exists in the citation of serious deficiencies."[21]

III. NURSING HOME CONDITIONS IN THE 1ST CONGRESSIONAL DISTRICT OF MISSOURI

There are 30 nursing homes in the 1st Congressional District of Missouri that accept residents whose care is paid for by Medicaid or Medicare. These nursing homes have 3,959 beds that were occupied by 2,673 residents during the most recent round of inspections. The majority of these residents, 2,200, rely on Medicaid to pay for their nursing home care. Medicare pays the cost of care for 234 residents. Seventy percent of the 30 nursing homes in the 1st Congressional District of Missouri are private, for-profit nursing homes.

The results of this investigation indicate that 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.

---

[20]GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 12, at 12-14.

[21]GAO, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, 16 (Sept. 2000).

A. Prevalence of Violations

None of the nursing homes in Rep. Clay's district was found by the state inspections to be in full or substantial compliance with federal standards of care. All 30 nursing homes in the district had at least one violation that had the potential to cause more than minimal harm to their residents or worse. Fifteen homes had violations that caused actual harm to residents or had the potential to cause death or serious injury. Table 2 summarizes these results.

Table 2: Nursing Homes in Rep. Clay's District 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)	0	0%	0
Substantial Compliance (Risk of Minimal Harm)	0	0%	0
Potential for More than Minimal Harm	15	50%	1,078
Actual Harm to Residents	9	30%	900
Actual or Potential Death/Serious Injury	6	20%	695

Many nursing homes had multiple violations. During recent inspections, state inspectors found a total of 384 violations in these 30 nursing homes, or an average of 13 violations per facility.

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 the G-level or above. As shown in Table 2, 15 nursing homes in the 1st Congressional District of Missouri had violations that fell into this category. Six of these nursing homes had violations that were severe enough to cause death or serious injury. Moreover, seven nursing homes had two or more actual harm violations.

In total, one-half of the nursing homes in the district caused actual harm to residents or worse. These facilities serve 1,595 residents and are estimated to receive over $23 million in federal and state funds each year.

C. Potential for Underreporting of Violations

The report's analysis of the prevalence of nursing home violations was based in large part on data reported to CMS in the OSCAR database. According to GAO, even though this database is "generally recognize[d] . . . as reliable," it may "understate the extent of deficiencies."[22] One

[22]GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 12, at 30.

problem, according to GAO, is 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."[23] A second problem is that state inspectors often miss significant violations. A recent GAO report 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 nursing homes. The federal inspectors also find many more violations of federal health and safety standards.[24] Consequently, 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."[25] 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."[26] As an example of such a technical violation, AHCA has claimed that the cancellation of a painting class would constitute a serious deficiency.[27]

At the national level, these assertions have proven to be erroneous. In response to AHCA's criticisms, GAO 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."[28] GAO found that many of the deficiencies affected multiple residents and that two-thirds of these homes had been cited for violations that were as severe as or even more severe in

---

[23]GAO, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, 4 (July 1998).

[24]*Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, *supra* note 21, at 43.

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

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

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

[28]GAO, *Nursing Homes: Proposal to Enhance Oversight*, *supra* note 13, at 2.

previous or subsequent annual inspections.[29]

This report undertook a similar analysis at the local level. To assess the severity of violations at nursing homes in Rep. Clay's district, the Special Investigations Division examined the state inspection forms for 16 nursing homes in the district with multiple, serious violations. These inspection forms contained numerous examples of neglect and mistreatment of residents. The violations documented in the reports included improper medical care, preventable accidents, inadequate nutrition, abuse, and untreated pressure sores.

One of the most disturbing findings from the review of the inspection reports was that the serious violations were not limited to violations that caused actual harm (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 families of residents as unacceptable. 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 some examples of the violations documented in the inspection reports.

A. Failure to Provide Proper Medical Care

State inspectors found numerous examples of residents not receiving proper medical care. For example, state inspectors cited two facilities for not preventing residents from developing urinary tract infections. Both facilities failed to clean feces from residents' catheters during incontinence care, even though the residents had a history of urinary tract infections.[30]

Another facility failed to properly isolate a resident with a potentially infectious wound. The resident was found sleeping on other residents' beds and couches without a dressing on his wound, thus exposing the other residents to a "greenish, yellow colored drainage which had a foul odor."[31]

---

[29]*Id.* at 6. A subsequent GAO study in August 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. The GAO report stated: "In our analysis of the cases that AHCA selected as 'symptomatic of a regulatory system run amok,' we did not find evidence of inappropriate regulatory actions." Letter from Kathryn G. Allen (GAO) to Sen. Charles E. Grassley, 2 (Aug. 13, 1999).

[30]Form 2567 for Nursing Home in St. Louis (Jan. 11, 2001) (D-level violation); Form 2567 for Nursing Home in Florissant (July 19, 2000) (D-level violation).

[31]Form 2567 for Nursing Home in Florissant (Dec. 13, 1999) (D-level violation).

At one facility, inspectors found that a resident's wound had worsened significantly because it had not been regularly treated. The director of nursing admitted that "she does not believe the wound would have gotten deeper and larger if the treatment had been done as ordered."[32]

Inspectors cited several nursing homes for not providing necessary restorative therapy and therapeutic devices, such as braces and splints, to residents.[33] For example, a resident at one facility was supposed to be ambulated three times a week, yet state inspectors found that he had not been walked for two months.[34] At another facility, inspectors found that two residents with degenerative joint diseases received no therapy for three months.[35] At same nursing home, a resident was left in bed for days despite a physician's order that she regularly use a wheelchair.[36]

State inspectors also cited several facilities for not properly administering medications or, in some cases, completely failing to administer the medications.[37] At one facility, a resident diagnosed with heart disease did not receive medication prescribed to prevent chest pains. A resident at the same facility did not receive an anti-anxiety medication prescribed by a physician, even though the resident was observed "yelling and flailing her body and limbs" when her pressure sores were treated.[38]

B. Failure to Prevent Falls and Accidents

State inspectors found many examples of nursing home residents falling and being injured because of inadequate supervision by the facility. One nursing home was cited for failing to take measures to prevent a resident from falling at least eight times over a two and a half month period, which caused the resident to suffer serious head, arm, and leg injuries. On two occasions, the resident, who received a blood thinner each day that put her at high risk for bleeding, required

---

[32]Form 2567 for Nursing Home in St. Louis (May 3, 2000) (D-level violation).

[33]Form 2567 for Nursing Home in Ferguson (Feb. 18, 2001) (D-level violation) (this home subsequently changed operator); Form 2567 for Nursing Home in St. Louis (May 24, 2000) (E-level violation); Form 2567 for Nursing Home in St. Louis (July 22, 1999) (E-level violation);

[34]Form 2567 for Nursing Home in St. Louis (Nov. 8, 2000) (D-level violation).

[35]Form 2567 for Nursing Home in Ferguson (Mar. 30, 2000) (E-level violation).

[36]Form 2567 for Nursing Home in Ferguson (Mar. 30, 2000) (E-level violation).

[37]Form 2567 for Nursing Home in St. Louis (June 26, 2000) (E-level violation); Form 2567 for Nursing Home in Ferguson (Mar. 30, 2000) (E-level violation); Form 2567 for Nursing Home in St. Louis (July 22, 1999) (E-level violation).

[38]Form 2567 for Nursing Home in Florissant (July 19, 2000) (D-level violation).

emergency room treatment. Another fall resulted in a fractured femur that required surgery.[39]

At one facility, a resident with a history of falling out of her wheelchair was left alone and unrestrained in her wheelchair. The director of nursing heard a "loud noise" coming from the resident's room and found the resident lying face down on the floor with blood coming out of her left forehead. The resident had to be taken to a hospital for treatment.[40] At a third nursing home, a resident fell multiple times and suffered cuts and internal bleeding, once requiring emergency room treatment.[41]

At several facilities, residents were injured while being transferred or moved by staff.[42] A resident at one nursing facility suffered multiple skin tears while being turned in bed. Even though blood was observed on the resident's bed rails, the facility made no effort to investigate the cause of the injuries or provide padding for the bed rails.[43]

At another nursing home, a resident who weighed only 81 lbs. and whose legs could not bear any weight was observed being roughly transferred by a nurse aide from her wheelchair to her bed. According to inspectors, the aide "lifted [the resident] eight inches off of the bed, and dropped her into the middle of the bed." Inspectors observed that the resident's body "bounced when she hit the mattress."[44]

C. Failure to Prevent or Properly Treat Pressure Sores

State inspectors found a variety of violations relating to pressure sores, including: failing to prevent pressure sores; failing to properly treat pressure sores; and leaving residents in the same position for hours instead of regularly repositioning them.[45] For example:

---

[39]Form 2567 for Nursing Home in Ferguson (Mar. 30, 2000) (G-level violation).

[40]Form 2567 for Nursing Home in St. Louis (Mar. 26, 1999) (G-level violation) (this home subsequently changed operator).

[41]Form 2567 for Nursing Home in St. Louis (Sept. 8, 2000) (D-level and G-level violations).

[42]Form 2567 for Nursing Home in St. Louis (Oct. 19, 2000) (D-level violation); Form 2567 for Nursing Home in Ferguson (Mar. 30, 2000) (G-level violation).

[43]Form 2567 for Nursing Home in Florissant (Dec. 13, 1999) (D-level and E-level violations).

[44]Form 2567 for Nursing Home in St. Louis (Aug. 16, 2000) (E-level violation).

[45]Form 2567 for Nursing Home in St. Louis (Dec. 15, 2000) (B-level violation); Form 2567 for Nursing Home in St. Louis (Oct. 19, 2000) (E-level violation); Form 2567 for Nursing

- At one facility, a resident's sores were covered with "black necrotic tissue," which had to be surgically removed. A week later, the resident was hospitalized for a blood infection caused by the sores.[46]

- A resident at another facility had pressure sores, some covered with "black leathery dead tissue," others with "yellow slough." When state inspectors visited the facility two months later, this resident had developed additional pressure sores and was still not receiving proper treatment.[47]

State inspectors found several instances of residents with pressure sores being left in the same position for hours:

- A resident with multiple sores was not repositioned or treated properly. Despite suffering from an open cancerous lesion on his right ear, he was observed with his right ear resting on a pillow for several hours at a time.[48]

- In another case, a resident had a pressure sore on her left hip that measured 3 cm. x 2 cm. that was surrounded by another sore that measured 10 cm. x 10 cm., yet the resident was left in a chair for over four hours without a pressure relieving device.[49]

- A facility failed to take proper precautions with a resident whose left leg was recently amputated due to an infected pressure sore and who now had a severe sore on his right heel. Even though his physician had ordered that the right heel be elevated, inspectors observed numerous instances in which the resident's heel was in direct contact with the

---

Home in St. Louis (Aug. 16, 2000) (D-level violation); Form 2567 for Nursing Home in St. Louis (July 26, 2000) (D-level violation); Form 2567 for Nursing Home in St. Louis (May 24, 2000) (D-level violation); Form 2567 for Nursing Home in St. Louis (May 3, 2000) (E-level violation); Form 2567 for Nursing Home in Ferguson (Mar. 30, 2000) (E-level violation); Form 2567 for Nursing Home in St. Louis (Mar. 14, 2000) (D-level violation); Form 2567 for Nursing Home in St. Louis (June 3, 1999) (D-level violation) (this home subsequently changed operator).

[46]Form 2567 for Nursing Home in Ferguson (Feb. 18, 2001) (G-level violation) (this home subsequently changed operator).

[47]Form 2567 for Nursing Home in St. Louis (Sept. 23, 1999) (G-level violation); Form 2567 for Nursing Home in St. Louis (July 22, 1999) (G-level violation);

[48]Form 2567 for Nursing Home in St. Louis (May 24, 2000) (E-level violation).

[49]Form 2567 for Nursing Home in St. Louis (Aug. 18, 2000) (D-level violation).

floor or bed, often for hours at a time.[50]

D. Abuse and Mistreatment of Residents

Several nursing homes were cited for failing to properly investigate injuries of unknown origin that might be evidence of abuse. The injuries involved large bruises, bone fractures, hematomas, and lacerations that required hospital treatment.[51] At one facility, five residents had suspicious injuries that were not properly investigated. One resident had "massive bruising" on her upper back that extended around to the center of her chest. A chest x-ray subsequently revealed a fractured rib. According to state inspectors, the facility's investigation of the injury was incomplete, inconclusive, and "contained scanty information."[52]

At another facility, residents complained of rough handling and verbal abuse from a nurse aide. Even though one resident was found crying after the alleged abuse, the facility did not investigate the incident. State inspectors also found that the facility had failed to conduct proper background checks of its employees in the past.[53]

State inspectors also found that some facilities failed to take appropriate precautions to prevent residents from abusing other residents. One facility did not provide activities to residents of the Alzheimer's unit, even though, according to a staff member, "there is not enough for the residents to do, so they end up beating up on each other." Several residents in the unit had a history of "physically abusive," "combative," or "aggressive" behavior. One resident was involved in five incidents of combative behavior over an eight-day period, including hitting staff and other residents. Another resident was involved in seven incidents of combative behavior over a two month period. However, the director of nursing said the second resident had not exhibited a pattern of abuse, because the resident "had not hurt anyone and because she did not hit other residents on a daily basis."[54]

E. Failure to Provide Adequate Nutrition and Hydration

Several St. Louis area nursing homes were cited for failing to provide adequate nutrition to

---

[50]Form 2567 for Nursing Home in St. Louis (Aug. 16, 2000) (D-level violation).

[51]Form 2567 for Nursing Home in St. Louis (June 26, 2000) (E-level violation); Form 2567 for Nursing Home in Ferguson (Mar. 30, 2000) (G-level violation); Form 2567 for Nursing Home in St. Louis (June 3, 1999) (D-level violation) (this home subsequently changed operator).

[52]Form 2567 for Nursing Home in Florissant (July 19, 2000) (E-level violation).

[53]Form 2567 for Nursing Home in St. Louis (Nov. 8, 2000) (E-level violation).

[54]Form 2567 for Nursing Home in Florissant (Dec. 21, 1999) (H-level violation).

residents. For example, a nurse at one facility told state inspectors that "there is not enough food for the residents," and that "they often go to bed hungry."[55]

At one facility, a resident was supposed to receive a nutritional supplement through her feeding tube every four hours. When inspectors reviewed her medical records, they found that she had not received the supplement over 180 times during a two and a half month period.[56] Another facility failed to provide nutritional supplements to a 82 lb. resident that were recommended by a dietician.[57]

State inspectors found some residents did not receive proper nutrition because the facilities failed to monitor their weights. At one facility, the recorded weight of a resident, whose amount of tube feeding was to be determined in part by her weight, was the same for five consecutive months. When the inspector requested that the resident be weighed again, she weighed 20 lbs. more than her recorded weight. An administrator then admitted that the resident had not actually been weighed in previous months. Another resident at the same facility had her right leg amputated, yet her recorded weight stayed the same. When inspectors asked that the resident be reweighed, she was found to weigh 45 lbs. less than recorded by the facility.[58]

State inspectors also found that nursing homes failed to take precautions with residents with special nutritional needs. At one nursing home, inspectors observed the staff repeatedly giving inappropriately thick liquids to a resident who had difficulty swallowing and was at risk for aspiration. On one occasion, the liquids caused coughing so severe that his physician had to be contacted.[59] At the same facility, inspectors observed the staff feeding sweetened foods and drinks to a diabetic resident, despite a physician's order that he not receive concentrated sweets.[60]

Nursing homes were also cited for failing to provide adequate fluids to residents. A resident with a history of fevers and dehydration was given 20 oz. of fluids one day instead of the required 57 oz. a day. Later that evening, she developed a fever of 102.3 degrees and had to be put on intravenous fluids for three days.[61]

---

[55]Form 2567 for Nursing Home in St. Louis (Oct. 19, 2000) (C-level violation).

[56]Form 2567 for Nursing Home in St. Louis (Aug. 16, 2000) (E-level violation).

[57]Form 2567 for Nursing Home in Ferguson (Mar. 30, 2000) (D-level violation).

[58]Form 2567 for Nursing Home in St. Louis (Sept. 8, 2000) (E-level violation).

[59]Form 2567 for Nursing Home in St. Louis (Jan. 10, 2000) (E-level violation).

[60]Form 2567 for Nursing Home in St. Louis (Jan. 10, 2000) (D-level violation).

[61]Form 2567 for Nursing Home in Ferguson (Mar. 30, 2000) (D-level violation).

F. Failure to Properly Clean and Care for Residents

A common problem at many St. Louis area nursing homes was the failure to properly clean and care for residents. State inspectors found numerous facilities in which residents were left for long periods of time in clothes and bed sheets saturated with urine and soiled with feces.[62] Inspectors observed instances in which staff members walked by urine-saturated residents without making any effort to change them.[63] For example:

- Nurses at one facility failed to clean a resident even though there was "a urine odor emanating from her" and a "dry yellow ring on her hospital gown." State inspectors observed that when the nurses finally lifted the covers to clean her, the nurses "made a face and turned their heads because of the odor."[64]

- At another nursing home, state inspectors found a resident wearing sweatpants wet with urine. Even though the resident had a "strong odor of urine about him," he continued to move around facility in his wheelchair, including eating dinner, for more than six hours before the staff changed his clothes.[65]

- State inspectors discovered a resident wearing urine saturated pants who was taken to the dining room for breakfast without being changed. When the inspectors returned to the facility two months later, they found the same resident sitting in her room with her pants soiled with feces and a "fecal odor permeating her room." A nurse took her to lunch without cleaning her. In the dining room, the "fecal soiled area of her pants was visible and there was a fecal odor in the corner of her room where she was sitting." After lunch, a nurse returned the resident to her room without cleaning her or changing her pants.[66]

---

[62]Form 2567 for Nursing Home in St. Louis (July 26, 2000) (E-level violation); Form 2567 for Nursing Home in Florissant (July 19, 2000) (D-level violation); Form 2567 for Nursing Home in St. Louis (Jan. 10, 2000) (D-level violation); Form 2567 for Nursing Home in Florissant (Dec. 21, 1999) (E-level violation); Form 2567 for Nursing Home in St. Louis (Sept. 23, 1999) (E-level violation); Form 2567 for Nursing Home in St. Louis (July 22, 1999) (E-level violation); Form 2567 for Nursing Home in St. Louis (June 3, 1999) (D-level violation) (this home subsequently changed operator); Form 2567 for Nursing Home in St. Louis (Mar. 26, 1999) (D-level violation) (this home subsequently changed operator).

[63]Form 2567 for Nursing Home in St. Louis (June 26, 2000) (D-level violation).

[64]Form 2567 for Nursing Home in Ferguson (Mar. 30, 2000) (E-level violation).

[65]Form 2567 for Nursing Home in St. Louis (Sept. 8, 2000) (D-level violation).

[66]Form 2567 for Nursing Home in St. Louis (Mar. 14, 2000) (D-level violation).

State inspectors found that other facilities failed to adequately clean residents. At one nursing home, a resident was observed with "two half dollar size pink excoriated areas on the left side of his scrotum." Three days later inspectors found him lying on an incontinent pad "soiled with saucer size smears of fecal material and thick mucus like drainage from the excoriated areas on his scrotum." And when two nursing assistants did clean him, they "left thick dark gray colored foul smelling material in the creases of his groin area and on the sides of his scrotum." More than a full day later, he "was still soiled with the same foul smelling material."[67]

At another facility, inspectors found residents with: "very foul body odor"; "thick black colored material caked underneath the fingernails"; "thick, pasty, foul-smelling, tan material between her toes on both feet"; and teeth that had "pale yellow colored pasty foul smelling layer of material."[68] At the same facility, one resident "smelled so bad" that family members had to bathe the resident themselves. The director of nurses admitted to state inspectors that residents were not receiving enough showers because the facility was having trouble regulating water temperatures.[69]

G. Inadequate Staffing

The failure of some facilities to properly care for residents was due to inadequate staffing. At one facility, residents said that there was not enough staff to change their diapers, so their clothes became wet with urine. One resident told inspectors that he is "lucky . . . to get a bath once a week." Another resident said that on one occasion, he "was left in bed for three days, because they did not have anyone to get him up."[70]

At another facility, a nurse aide said it was "impossible to provide good care to the number of residents on her assignment in the time she has to get it done." Another aide said that "they don't always have enough staff to keep the residents clean [and] dry." A family member of a resident complained that "she finds her mother soaked with urine."[71]

Staff members at one facility admitted that they were exhausted at the end of their shifts because of the short staffing, and they were unable to provide proper care. One family member said the staffing situation was "really really terrible," and that she had found her mother saturated

---

[67]Form 2567 for Nursing Home in St. Louis (May 24, 2000) (D-level violation).

[68]Form 2567 for Nursing Home in St. Louis (May 3, 2000) (E-level violation).

[69]Form 2567 for Nursing Home in St. Louis (May 3, 2000) (E-level violation).

[70]Form 2567 for Nursing Home in St. Louis (Oct. 19, 2000) (E-level violation).

[71]Form 2567 for Nursing Home in Florissant (Sept. 13, 2000) (B-level violation).

with urine at least ten times in the previous four months.[72]

H. Other Violations

Several facilities were cited for their failure to provide an acceptable physical environment. One facility was cited for an L-level deficiency, the most serious violation, because it did not have functional fire alarm system in many parts of the facility.[73]

At another facility, state inspectors found the temperature near one resident's bed to be 56 degrees. Residents told inspectors "if you think it was cold now you should be here in the middle of the night," and "it was like an icicle in here last night."[74]

State inspectors also found a number of violations that, while not causing immediate harm, reflected the indifferent care that is provided to many residents. For example, residents at one facility were served milk that was 80 degrees, 35 degrees warmer than the proper serving temperature. At another meal, residents were served milk as much as eleven days after the expiration date listed on the cartons.[75]

At another facility, inspectors observed a nurse aide wash urine from a resident's perineal area and then, without washing her hands or changing her gloves, the aide rinsed the resident's toothbrush and "us[ed] her thumb to remove the toothpaste."[76]

At several facilities, state inspectors found residents whose private areas were left visible to passersby in the hallway.[77] At one nursing home, inspectors observed a resident sitting in her room completely naked except for socks. Even though the resident was in plain view of the

---

[72]Form 2567 for Nursing Home in Ferguson (Mar. 30, 2000) (F-level violation).

[73]Form 2567 for Nursing Home in St. Louis (May 3, 2000) (L-level violation).

[74]Form 2567 for Nursing Home in St. Louis (Dec. 15, 2000) (D-level violation).

[75]Form 2567 for Nursing Home in St. Louis (July 22, 1999) (E-level violation).

[76]Form 2567 for Nursing Home in Florissant (Dec. 21, 1999) (D-level violation).

[77]Form 2567 for Nursing Home in St. Louis (Oct. 19, 2000) (E-level violation); Form 2567 for Nursing Home in St. Louis (June 26, 2000) (D-level violation); Form 2567 for Nursing Home in Florissant (Dec. 21, 1999) (E-level violation).

hallway, she was not covered by a staff member who looked into the room.[78]

State inspectors observed a licensed nurse at another facility conducting fingerstick blood tests on four residents in a unnecessarily forceful manner. In each case, the nurse "jabbed the lancet into [the resident's] finger with such force that his finger bent backward." All four residents "yelled and said that it hurt." One resident said, "I think you hit the bone. That really hurt. Why are you always so mean."[79]

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 the nursing homes in Rep. Clay's district has been poor. This report reviewed the OSCAR and complaint databases and a sample of actual state inspection reports. The same conclusion emerges from both analyses: many nursing homes in the 1st Congressional District of Missouri are failing to provide the care that the law requires and that families expect.

[78]Form 2567 for Nursing Home in St. Louis (July 22, 1999) (D-level violation).

[79]Form 2567 for Nursing Home in St. Louis (Aug. 16, 2000) (D-level violation).