Nursing Home Conditions in the 13th Congressional District of Pennsylvania: Many Homes Fail to Meet Federal Standards for Adequate Care

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Prepared for Rep. Joseph M. Hoeffel

Minority Staff
Special Investigations Division
Committee on Government Reform
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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. Joseph M. Hoeffel 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 13th congressional district of Pennsylvania, which consists of most of Montgomery County and is adjacent to Philadelphia. There are 59 nursing homes in Rep. Hoeffel's district that accept residents covered by Medicaid or Medicare. These homes serve approximately 5,700 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 many of the nursing homes in Rep. Hoeffel's district. Over 70% of the nursing homes in the district violated federal health and safety standards during recent state inspections. Moreover, more than 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 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. It examines recent annual inspections of nursing homes in the 13th Congressional District of Pennsylvania. These inspections were conducted from December 1999 to May 2001. In addition, the report examines the results of any complaint investigations conducted during this time period.

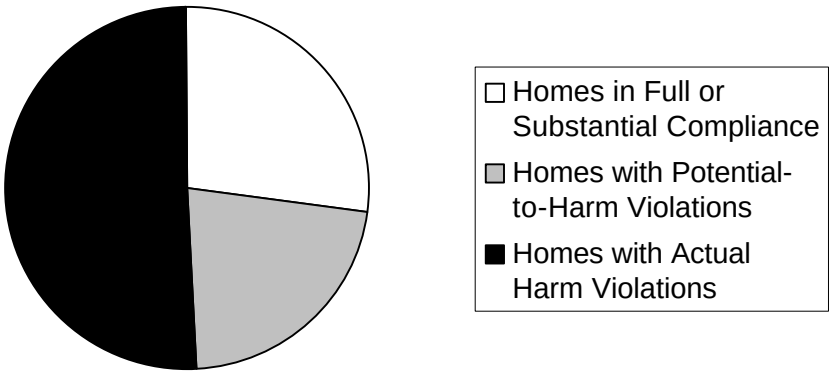
Because this report is based on recent state inspections, the results are representative of current nursing home conditions in the district as a whole. However, conditions in individual homes can change. New management or enforcement activities can bring rapid improvement; other changes can lead to sudden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

Most nursing homes in Rep. Hoeffel'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 59 nursing homes in Rep. Hoeffel's district, only 16 homes (27%) were found to be in full or substantial compliance with the federal standards. In contrast, 43 nursing homes (73%) had at least one violation with the potential to cause more than minimal harm to residents or worse. On average, each of these 43 nursing homes had 7.6 violations of federal quality of care requirements.

Many nursing homes in Rep. Hoeffel's district had violations that caused actual harm to residents. Of the 59 nursing homes in Rep. Hoeffel's district, 30 homes -- more than 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. The most frequently cited violations causing actual harm involved the failure to prevent accidents to residents and improper medical care. The 30 homes with actual harm violations serve 2,905 residents and are estimated to receive over $57 million each year in federal and state funds.

Figure 1: Compliance Status of Nursing Homes in the 13th 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 18 homes that were cited for multiple, serious violations were examined in detail. The inspection reports documented that the actual harm violations cited by state inspectors were for neglect and mistreatment of residents, including at least one violation that contributed to the death of a resident. 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 1.6 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 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 and Sex with Special Age Categories: Middle Series 2025-2045* (Dec. 1999).

[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. 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 residents. They require nursing homes to prevent pressure sores, which are painful wounds or

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[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).

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

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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).

[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. Joseph M. Hoeffel 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. Hoeffel represents the 13th congressional district of Pennsylvania, which consists of most of Montgomery County and is adjacent to Philadelphia. This report presents the results of this investigation. It is the first congressional report to comprehensively investigate nursing home conditions in the 13th congressional district of Pennsylvania.

II. METHODOLOGY

To assess the conditions in nursing homes in Rep. Hoeffel'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 18 nursing homes in Rep. Hoeffel's district.

A. Determination of Compliance Status

Data on the compliance status of nursing homes in Rep. Hoeffel's district comes from the OSCAR database and the complaint database. These databases are compiled by the Health Care Financing Administration (HCFA), a division of HHS. HCFA 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 HCFA, and compiled in the OSCAR and complaint databases.[18]

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 of actual harm to residents) and the scope (the number of residents affected) of the violation. As

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

[18]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, HCFA maintains a website (http://www.medicare.gov/nhcompare/home.asp) where the public can obtain data about individual nursing homes.

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. Hoeffel'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 December 1999 and May 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 13th congressional district. These inspection reports, prepared on a HCFA 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 18 nursing homes that were cited for multiple, serious violations. For each of these homes, a recent state inspection report was obtained from the Pennsylvania Department of Health. For several of these nursing homes, the Special Investigations Division also obtained reports of other inspections and investigations conducted by the Pennsylvania Department of Health over the past two and a half 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. Hoeffel'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.[19]

For this reason, this report should be considered a representative "snapshot" of nursing home conditions in the 13th 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. Hoeffel'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."[20]

III. NURSING HOME CONDITIONS IN THE 13TH CONGRESSIONAL DISTRICT OF PENNSYLVANIA

There are 59 nursing homes in the 13th congressional district of Pennsylvania that accept residents whose care is paid for by Medicaid or Medicare. These nursing homes have 6,448 beds that were occupied by 5,680 residents during the most recent round of inspections. The majority of these residents, 3,018, rely on Medicaid to pay for their nursing home care. Medicare pays the cost of care for 425 residents. Thirty-nine percent of the 59 nursing homes in the 13th congressional district of Pennsylvania 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.

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

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

A. Prevalence of Violations

Only 16 of the nursing homes in Rep. Hoeffel's district were found by the state inspections to be in full or substantial compliance with federal standards of care. The rest of the nursing homes in the district -- 43 out of 59 -- had at least one violation that had the potential to cause more than minimal harm to their residents or worse. Thirty 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. Hoeffel'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)	15	25%	1,388
Substantial Compliance (Risk of Minimal Harm)	1	1.7%	8
Potential for More than Minimal Harm	13	22%	1,379
Actual Harm to Residents	29	49%	2,798
Actual or Potential Death/Serious Injury	1	1.7%	107

Many nursing homes had multiple violations. During recent inspections, state inspectors found a total of 327 violations in homes that were not in complete or substantial compliance with federal requirements, or an average of 7.6 violations per noncompliant home.

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, 30 nursing homes in the 13th congressional district of Pennsylvania had violations that fell into this category. Seventeen nursing homes had two or more actual harm violations. In total, 51% of the nursing homes in the district caused actual harm to residents or worse. These homes serve 2,905 residents and are estimated to receive over $57 million in federal and state funds each year.

C. Most Frequently Cited Violations Causing Actual Harm

During the most recent annual inspections, state inspectors cited the nursing homes in Rep. Hoeffel's district for 69 violations causing actual harm to residents. These violations fell into several different deficiency areas.

The most common actual harm violation cited by Pennsylvania inspectors violations was the failure to prevent accidents to residents, such as falls that cause broken or fractured bones or skin lacerations. Twenty nursing homes in Rep. Hoeffel's district were cited for violations of the federal requirement that "[e]ach resident receives adequate supervision and assistance devices to

prevent accidents."[21]

Another frequently cited actual harm violation involved improper medical care. This violation included failing to provide necessary treatments, failing to properly administer medications, and failing to promptly notify physicians of changes in resident conditions. Nineteen nursing homes in Rep. Hoeffel's district were cited for these types of violations.

Eleven nursing homes in Rep. Hoeffel's district were cited for actual harm violations involving the failure to treat or prevent 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 frequent turning of residents to relieve pressure on one part of the body.

D. Potential for Underreporting of Violations

The report's analysis of the prevalence of nursing home violations was based in large part 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."[22] One 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 the 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.

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[21]42 C.F.R. §483.25(h).

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

[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 20, at 43.

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 than violations cited in 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. Hoeffel's district, the Special Investigations Division examined the state inspection forms for 18 nursing homes in the district with multiple, serious violations. These inspection forms contained numerous examples of neglect and mistreatment of residents, including one violation that contributed to the death of a resident. The violations

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[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.

[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).

documented in the reports included improper medical care, preventable accidents, inadequate nutrition and hydration, 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 most 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 Prevent Falls and Accidents

Preventable falls and accidents were a common type of violation documented in the state inspection reports. These violations are also serious because falls and other accidents can result in severe injuries, including death, as occurred at one nursing home.

In the case involving the fatality, inspectors found that the nursing home failed to implement adequate measures to prevent a resident with dementia and poor vision from falling at least four times in ten months. The first three falls caused the resident to injure her eyes, forehead, nose, and right knee. Although the fourth fall was initially reported by the facility as having caused no injury, the resident actually fractured her femur, which contributed to the resident's death nine days after the fall.[30]

At the same home, a 78-year-old male resident who received inadequate supervision sustained 11 falls over six months, ten of which occurred from his bed despite a physician order requiring that side rails be applied. A third resident admitted to the home with a hip fracture suffered 13 falls in two months, while a fourth resident who was not adequately supervised fell 21 times in one year.[31]

At another facility, one resident fell 35 times during a five month period. One day, the resident fell three times in ten hours. State inspectors found no evidence to suggest that staff was monitoring this resident to prevent falls. Another resident at this facility was found on the floor 12 times in a three and a half month period. State inspectors found no evidence that the staff had

[30]HCFA Form 2567 for Nursing Home in Glenside (Jan. 25, 1999) (H-level violation).

[31]HCFA Form 2567 for Nursing Home in Glenside (Jan. 25, 1999) (E and H-level violations).

investigated the cause of these falls or taken steps to correct the problem.[32]

A resident at another facility fell out of his chair on three occasions because the staff had failed to apply a safety belt or alarm. State inspectors found that the home not only failed to investigate the incidents but also failed to implement measures to prevent their recurrence.[33] When inspectors returned to the same facility six months later, they found similar problems. One resident fell out of her chair on two occasions because the staff had failed to properly lock the chair into a reclining position. The resident fractured her nasal bone and bruised her cheeks as a result of the second incident.[34]

One facility did not even investigate the causes of several resident injuries. Among the injuries that were not investigated were a resident with a swollen leg and purple coloring on her left eye, a resident with bruising on her left ankle, a resident with a bruise on the side of the mouth, and a resident with a large bruise on the back of her left hand.[35]

B. Failure to Provide Proper Medical Care

Pennsylvania inspectors found many examples of nursing homes failing to provide necessary medical care. Nursing homes ignored obvious warning signals, failed to notify physicians of changes in residents' medical conditions, and improperly administered medications.

In one case, a nursing home failed to properly monitor a resident after the removal of his urinary catheter, despite a physician's order that the resident's progress be closely tracked after the procedure. The resident was observed by the staff in pain and with a distended abdomen five days after the catheter's removal, and on the sixth day, an "excessive" amount of "milky-colored urine" was removed from his body. The resident was subsequently hospitalized for dehydration and urosepsis, a serious infection caused by the decomposition of urine that has escaped into the body.[36]

At another facility, a diabetic resident required hospitalization after the staff failed to take steps to control her blood sugar level. Even though the resident's blood sugar level was recorded to be more than three times above normal, the facility did nothing for 14 hours. The resident was subsequently hospitalized for "uncontrolled diabetes." According to hospital records, the

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[32]HCFA Form 2567 for Nursing Home in Lansdale (Jan. 12, 2001) (G-level violation).

[33]HCFA Form 2567 for Nursing Home in Pottstown (Mar. 17, 2000) (D-level violation).

[34]HCFA Form 2567 for Nursing Home in Pottstown (Sept. 1, 2000) (G-level violation).

[35]HCFA Form 2567 for Nursing Home in Wyncote (Feb. 11, 2000) (E-level violation).

[36]HCFA Form 2567 for Nursing Home in Norristown (Nov. 2, 1999) (J-level violation).

resident's blood sugar level was more than eight times above normal when she was admitted.[37]

State inspectors found multiple examples of physician orders not being followed at another facility: residents were not receiving required oxygen; blood sugar levels of diabetic residents were not checked twice daily; pulse rates were not checked before the administration of certain medications; heart and kidney medications were not administered because they were not available; a tuberculosis test was not completed; and wounds were not regularly treated.[38] When state inspectors returned for a follow-up inspection several months later, they continued to find that pulse rates were not checked before certain medications were given; physician-ordered treatments, including wound treatments, were not provided; and medications were not administered because they were not available.[39]

State inspectors cited several nursing homes in Rep. Hoeffel's district for a variety of errors involving the administration of medication, including: failing to monitor medications for adverse side effects,[40] failing to follow a pharmacist recommendation to reduce the administration of psychoactive medications,[41] and storing insulin at the wrong temperature.[42]

Nursing homes were also found to have improperly administered pain medication.[43] At one nursing home, for example, state inspectors observed a resident in evident pain, awkwardly positioned in her wheelchair, where she remained alone in a room from morning until the evening meal for two straight days. According to inspectors, the resident "grimaced, shifted her weight" and placed her head on a table in front of her, which she explained was "the only way that she

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[37]HCFA Form 2567 for Nursing Home in Hatboro (Dec. 7, 2000) (G-level violation).

[38]HCFA Form 2567 for Nursing Home in Pottstown (Mar. 17, 2000) (D and E-level violations).

[39]HCFA Form 2567 for Nursing Home in Pottstown (June 6, 2000) (D and E-level violations).

[40]HCFA Form 2567 for Nursing Home in Roslyn (Nov. 29, 2000) (D-level violation) (the ownership of this home has recently changed); HCFA Form 2567 for Nursing Home in Roslyn (June 21, 2000) (D-level violation) (the ownership of this home has recently changed); HCFA Form 2567 for Nursing Home in Pottstown (Mar. 17, 2000) (D-level violation); HCFA Form 2567 for Nursing Home in Lansdale (Feb. 4, 2000) (D-level violation).

[41]HCFA Form 2567 for Nursing Home in Ambler (Dec. 29, 1999) (D-level violation).

[42]HCFA Form 2567 for Nursing Home in Roslyn (June 21, 2000) (E-level violation) (the ownership of this home has recently changed).

[43]HCFA Form 2567 for Nursing Home in Ambler (Dec. 29, 1999) (G-level violation); HCFA Form 2567 for Nursing Home in Norristown (Nov. 2, 1999) (K-level violation).

could be comfortable." Upon investigating, the state inspectors learned that the physician's order to provide pain medication was not followed, and there was no evidence of either medical intervention or an assessment to determine the cause of the resident's pain. The resident was subsequently hospitalized for a dilated and obstructed colon.[44]

Nursing homes are supposed to provide physical therapy and therapeutic devices to residents to ensure that they maintained their flexibility and mobility. Yet state inspectors found that some facilities failed to provide such care.[45]

C. Failure to Provide Adequate Nutrition and Hydration

State inspectors found that many nursing homes in Rep. Hoeffel's district also did not provide sufficient hydration and nutrition to residents. In several instances, the hydration violations resulted in medical complications that required hospitalization:

- At one nursing home, state inspectors examined the care provided over a 20-day period to a female resident who had previously suffered a urinary tract infection. The inspectors found that the resident did not receive adequate hydration for 19 out of the 20 days. Even after nurses observed that the resident exhibited symptoms of dehydration, there was no evidence that the staff notified a physician. The resident was subsequently hospitalized for acute renal failure due to dehydration.[46]

- State inspectors found that another facility failed to provide adequate fluids to a female resident every day for almost three months. During that time, the resident experienced a urinary tract infection and had to be hospitalized for dehydration.[47]

- A resident at another facility was hospitalized for dehydration after the staff failed to ensure that she was consuming enough liquids. The resident had recently been released from the hospital after suffering from dehydration, yet the staff failed to assist her when she had difficulty drinking the thickened liquids that she was given. After only a few

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[44]HCFA Form 2567 for Nursing Home in Norristown (Nov. 2, 1999) (K-level violation).

[45]HCFA Form 2567 for Nursing Home in Roslyn (June 21, 2000) (D-level violation) (the ownership of this home has recently changed); HCFA Form 2567 for Nursing Home in Pottstown (Mar. 17, 2000) (G-level violation).

[46]HCFA Form 2567 for Nursing Home in Wyncote (Feb. 18, 2000) (G-level violation).

[47]HCFA Form 2567 for Nursing Home in Montgomeryville (July 1, 1999) (G-level violation).

weeks, the resident had to be readmitted to the hospital for dehydration.[48]

- A fourth facility failed to notify a physician about the condition of a resident who was consuming far less liquids than required. The resident had a physician order to receive at least 78 oz. of fluids each day, but inspectors found that the resident's fluid consumption was as low as 11 oz. on some days. The resident was subsequently hospitalized for acute renal failure, hyperkalemia (high potassium level in the bloodstream), and dehydration.[49]

State inspectors cited several nursing homes for not providing adequate nutrition to residents. At one facility, inspectors found a resident whose weight dropped from 116 lbs to 85 lbs. in less than ten months. Inspectors found that the facility failed to monitor whether the resident was consuming recommended nutritional supplements.[50]

Another facility failed to regularly weigh residents following "significant unplanned weight loss." When inspectors asked a nurse for the weight records of one resident who had lost ten pounds the previous month, the nurse provided a weight of 128 lbs, which included the weight of the resident's wheelchair. The nurse admitted that she was "unaware of the resident's actual weight because she did not know the weight of the wheelchair."[51]

D. Abuse and Mistreatment of Residents

At one nursing home, widespread mistreatment compelled state inspectors to cite the facility for an L-level violation -- the most serious level of violation -- indicating that the inspectors had found numerous abuses with the potential to cause death or serious injury. Among the problems identified by inspectors were abuse of residents and failure to investigate injuries or other evidence of maltreatment.[52] For example:

- One resident was found with bruises under her right breast. No investigation of the injury was conducted, and within two weeks, the resident was found with six unidentified bruises on the front and back of her body.

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[48]HCFA Form 2567 for Nursing Home in Hatboro (Dec. 7, 2000) (G-level violation).

[49]HCFA Form 2567 for Nursing Home in Hatboro (Feb. 26, 2000) (G-level violation) (the ownership of this home has recently changed).

[50]HCFA Form 2567 for Nursing Home in Pottstown (Mar. 17, 2000) (G-level violation).

[51]HCFA Form 2567 for Nursing Home in Roslyn (June 21, 2000) (D-level violation) (the ownership of this home has recently changed).

[52]HCFA Form 2567 for Nursing Home in Norristown (Nov. 2, 1999) (L-level violations).

- The daughter of a resident discovered scratches on her mother's body that eventually blistered and required treatment. When she noted the same marks on her mother's roommate, the daughter reported concerns of abuse, but the home failed to investigate the incidents.

- A female resident was injured when staff members tried to forcibly feed her. The resident sustained a cut to her upper gum after a staff member "restrained the resident and held her nose" while another employee "forced the spoon into the resident's mouth."

- Residents reported being "tossed or thrown" into bed, while other residents said they were "pulled or yanked by an arm or hand in a painful manner."

According to state inspectors, another facility failed to investigate allegations of physical abuse of a resident, unexplained injuries suffered by two other residents, and seven incidents of resident property being stolen.[53]

The mistreatment at one home took the form of simple neglect. The state inspectors found that a resident who was completely dependent on staff was left in bed for 16 consecutive days with no documented reason for keeping him there.[54]

E. Failure to Prevent or Properly Treat Pressure Sores

The state inspection reports contained numerous examples of nursing homes that were cited for improper prevention and treatment of pressure sores. This is a serious violation because pressure sores, if untreated or not properly treated, can lead to infection, muscle and bone damage, and even death.

State inspectors found a wide array of violations involving pressure sores in the nursing homes. The violations included: leaving bedridden residents in the same position instead of regularly repositioning them, as required by standard medical procedures; failing to provide protective padding or pressure-relieving devices to residents at risk of developing pressure sores; failing to provide physician-ordered treatments; and failing to properly monitor existing sores on residents.[55]

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[53]HCFA Form 2567 for Nursing Home in Pottstown (Mar. 17, 2000) (E-level violation).

[54]HCFA Form 2567 for Nursing Home in Pottstown (Mar. 17, 2000) (D-level violation).

[55]HCFA Form 2567 for Nursing Home in Roslyn (Nov. 29, 2000) (D-level violation) (the ownership of this home has recently changed); HCFA Form 2567 for Nursing Home in Pottstown (Mar. 17, 2000) (G-level violation); HCFA Form 2567 for Nursing Home in Hatboro (Feb. 26, 2000) (G-level violation) (the ownership of this home has recently changed); HCFA Form 2567 for Nursing Home in Lansdale (Feb. 4, 2000) (G-level violation).

Residents were harmed by these violations. A resident at one facility required hospitalization after the staff failed to properly prevent pressure sores.[56] At another facility, inspectors found that a home failed to regularly reposition a dependent resident, causing one pressure sore to deteriorate so much that it had to be surgically removed.[57]

F. Failure to Properly Clean and Care for Residents

Federal standards require that nursing homes provide residents with "the necessary services to maintain good . . . grooming and personal and oral hygiene."[58] 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 by many nursing homes. For example:

- State inspectors noticed a strong urine odor inside two nursing homes.[59]
- At another nursing home, state inspectors found shower rooms that contained towels, pails, and privacy curtains that were soiled with feces.[60]
- At another nursing home, residents failed to receive timely assistance with toileting and were found in "urine-soaked pants."[61]

This indifference to the welfare and dignity of residents also extended to staff responsiveness to residents in need of assistance. State inspectors found that some facilities placed call bells out of reach of residents. For example, inspectors discovered a female resident who was unable to request needed assistance from the staff because her call bell was lying on the floor out of her reach. Several days later, the same resident was observed with her call bell again inaccessible.[62]

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[56]HCFA Form 2567 for Nursing Home in Norristown (Jan. 26, 2001) (G-level violation).

[57]HCFA Form 2567 for Nursing Home in Lansdale (Feb. 4, 2000) (G-level violation).

[58]42 C.F.R. §483.25(a)(3).

[59]HCFA Form 2567 for Nursing Home in Roslyn (Nov. 29, 2000) (B-level violation) (the ownership of this home has recently changed); HCFA Form 2567 for Nursing Home in Wyncote (Oct. 23, 2000) (B-level violation).

[60]HCFA Form 2567 for Nursing Home in Hatboro (Dec. 7, 2000) (D-level violation).

[61]HCFA Form 2567 for Nursing Home in Pottstown (Mar. 17, 2000) (E-level violation).

[62]HCFA Form 2567 for Nursing Home in Roslyn (Apr. 28, 2000) (B-level violation) (the ownership of this home has recently changed).

At another facility, residents said that when they activated their call bells that the staff would come into the room, turn off the call bells, and leave without providing needed care.[63]

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. Hoeffel'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 13th congressional district of Pennsylvania are failing to provide the care that the law requires and that families expect.

[63]HCFA Form 2567 for Nursing Home in Pottstown (Mar. 17, 2000) (E-level violation).