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NURSING HOMES

Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline

Statement of William J. Scanlon
Director—Health Care Issues

July 17, 2003

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Highlights

Highlights of GAO-03-1016T, a testimony before the Committee on Finance, U.S. Senate

Why GAO Did This Study

Since 1998, the Congress and Administration have focused considerable attention on improving the quality of care in the nation's nursing homes, which provide care for about 1.7 million elderly and disabled residents in about 17,000 homes. GAO has earlier reported on serious weaknesses in processes for conducting routine state inspections (surveys) of nursing homes and complaint investigations, ensuring that homes with identified deficiencies correct the problems without recurrence, and providing consistent federal oversight of state survey activities to ensure that nursing homes comply with federal quality standards.

GAO was asked to update its work on these issues and to testify on its findings, as reported in *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, GAO-03-561 (July 15, 2003). In commenting on this report, the Centers for Medicare & Medicaid Services (CMS) generally concurred with the recommendations to address survey and oversight weaknesses. In this testimony, GAO addresses (1) the prevalence of serious nursing home quality problems nationwide, (2) factors contributing to continuing weaknesses in states' survey, complaint, and enforcement activities, and (3) the status of key federal efforts to oversee state survey agency performance and improve quality.

www.gao.gov/cgi-bin/getrpt?GAO-03-1016T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen on (202) 512-7118.

What GAO Found

The magnitude of documented serious deficiencies that harmed nursing home residents remains unacceptably high, despite some decline. For the most recent period reviewed, one in five nursing homes nationwide (about 3,500 homes) had serious deficiencies that caused residents actual harm or placed them in immediate jeopardy. Moreover, GAO found significant understatement of care problems that should have been classified as actual harm or higher—serious avoidable pressure sores, severe weight loss, and multiple falls resulting in broken bones and other injuries—for a sample of homes with a history of harming residents. Several factors contributed to such understatement, including confusion about the definition of harm; inadequate state review of surveys to identify potential understatement; large numbers of inexperienced state surveyors; and a continuing problem with survey timing being predictable to nursing homes. States continue to have difficulty identifying and responding in a timely fashion to public complaints alleging actual harm—delays state officials attributed to an increase in the volume of complaints and to insufficient staff. Although federal enforcement policy was strengthened in January 2000 by requiring state survey agencies to refer for immediate sanction homes that had a pattern of harming residents, many states did not fully comply with this new requirement, significantly undermining the policy's intended deterrent effect.

While CMS has increased its oversight of state survey and complaint investigation activities, continued attention is required to help ensure compliance with federal requirements. In October 2000, the agency implemented new annual performance reviews to measure state performance in seven areas, including the timeliness of survey and complaint investigations and the proper documentation of survey findings. The first round of results, however, did not produce information enabling the agency to identify and initiate needed improvements. For example, some regional office summary reports provided too little information to determine if a state did not meet a particular standard by a wide or a narrow margin—information that could help CMS to judge the seriousness of problems identified and target remedial interventions. Rather than relying on its regional offices, CMS plans to more centrally manage future state performance reviews to improve consistency and to help ensure that the results of those reviews could be used to more readily identify serious problems. Finally, implementation has been significantly delayed for three federal initiatives that are critical to reducing the variation evident in the state survey process in categorizing the seriousness of deficiencies and investigating complaints. These delayed initiatives were intended to strengthen the methodology for conducting surveys, improve surveyor guidance for determining the scope and severity of deficiencies, and increase standardization in state complaint investigation processes.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you address the quality of care provided to the nation's 1.7 million nursing home residents, a highly vulnerable population of elderly and disabled individuals. The federal government plays a major role in ensuring nursing home quality and in financing nursing home care. Medicare and Medicaid paid the nation's approximately 17,000 homes an estimated $42 billion in 2002 to care for beneficiaries. More specifically, Medicaid pays for care provided to about two-thirds of all nursing home residents nationwide. In addition, the Department of Veterans Affairs contracts with many of these same nursing homes to provide long-term care to veterans at a cost of more than $250 million in fiscal year 2002. In 1998, the Senate Special Committee on Aging held a hearing to address nursing home care problems in California. Troubled by our findings of poor care in that state's homes and weak federal oversight in general, the Committee held additional hearings on nursing home quality nationwide in 1999 and 2000. In response to congressional oversight and our recommendations, the Administration has taken actions intended to address many of the weaknesses we identified. These weaknesses included:

- periodic state inspections, known as surveys, that understated the extent of serious care problems due to procedural weaknesses;
- considerable delays that occurred in states investigating complaints by residents, family members or friends, and nursing home staff alleging actual harm to residents;
- federal enforcement policies that did not ensure that identified deficiencies were addressed and remained corrected; and
- federal oversight of state survey activities that was often inconsistent across states and limited in scope and effectiveness.

In September 2000, we reported on progress made in addressing these weaknesses and concluded that the success of the Administration's actions to improve nursing home quality required sustained federal and state commitment to reach their full potential. My remarks today will address federal and state progress made since our September 2000 report and testimony, focusing in particular on (1) the prevalence of serious nursing home quality problems, (2) factors contributing to continuing weaknesses in states' survey, complaint, and enforcement activities, and (3) the status of key federal efforts to oversee state survey agency

performance and improve quality. My remarks are based on our report being released today that addresses these issues in greater detail.[1]

In summary, the magnitude of serious deficiencies that harmed nursing home residents remains unacceptably high, despite some decline. For the most recent period we reviewed, one in five of all nursing homes nationwide (about 3,500 homes) had serious deficiencies that caused residents actual harm or placed them in immediate jeopardy. Moreover, we found significant understatement of care problems that should have been classified as actual harm or higher—serious avoidable pressure sores, severe weight loss, and multiple falls resulting in broken bones and other injuries—for a sample of homes with a history of harming residents. We identified several factors that contributed to such understatement, including confusion about the definition of harm; inadequate state supervisory review of surveys to identify potential understatement; large numbers of inexperienced state surveyors; and a continuing, significant problem with survey timing being predictable to nursing homes. States also continue to have difficulty identifying and responding in a timely fashion to complaints alleging actual harm—delays that state officials attributed to an increase in the volume of complaints and to insufficient staff. Although federal enforcement policy was strengthened in January 2000 by requiring state survey agencies to refer for immediate sanction homes that had a pattern of harming residents, we found that many states did not fully comply with this new requirement. States failed to refer hundreds of homes for immediate sanction, significantly undermining the policy's intended deterrent effect.

While the Centers for Medicare & Medicaid Services (CMS) has increased its oversight of state survey and complaint investigation activities, continued attention is required to help ensure compliance with federal requirements.[2] In October 2000, the agency implemented new annual performance reviews to measure state performance in seven areas, including the timeliness of survey and complaint investigations and the proper documentation of survey findings. The first round of results,

[1]U.S. General Accounting Office, *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, GAO-03-561 (Washington, D.C.: July 15, 2003).

[2]Effective July 1, 2001, the name of the Health Care Financing Administration (HCFA) was changed to the Centers for Medicare & Medicaid Services. In this testimony we continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

however, did not produce information enabling the agency to identify and initiate needed improvements. For example, some regional office summary reports provided too little information to determine if a state agency did not meet a particular standard by a wide or a narrow margin—information that could help CMS to judge the seriousness of problems identified and target remedial actions. Rather than relying on its regional offices, CMS plans to more centrally manage future state performance reviews to improve consistency and to help ensure that the results of those reviews could be used to more readily identify serious problems. Finally, implementation has been significantly delayed for three federal initiatives that are critical to reducing the variation evident in the state survey process in categorizing the seriousness of deficiencies and investigating complaints. These delayed initiatives were intended to strengthen the methodology for conducting surveys, improve surveyor guidance for determining the scope and severity of deficiencies, and increase standardization in state complaint investigation processes. In our view, finalizing and implementing these initiatives as quickly as possible would help bring more clarity and consistency to the process for assessing and improving the quality of care provided to the nation's nursing home residents.

Background

Oversight of nursing homes is a shared federal and state responsibility. CMS is the federal agency that manages Medicare and Medicaid and oversees compliance with federal nursing home quality standards. On the basis of statutory requirements, CMS defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to certify that homes meet these standards through annual inspections and complaint investigations. The "annual" inspection, called a survey, which must be conducted on average every 12 months and no less than every 15 months at each home, entails a team of state surveyors spending several days in the home to determine whether care and services meet the assessed needs of the residents. CMS establishes specific protocols, or investigative procedures, for state surveyors to use in conducting these comprehensive surveys. In contrast, complaint investigations, also conducted by state surveyors within certain federal guidelines and time frames, typically target a single area in response to a complaint filed against a home by a resident, the resident's family or friends, or nursing home employees. Quality-of-care problems identified during either standard surveys or complaint investigations are classified in 1 of 12 categories according to their scope (the number of residents potentially or actually affected) and their severity (potential for or occurrence of harm to residents).

Ensuring that documented deficiencies are corrected is likewise a shared responsibility. CMS is responsible for enforcement actions involving homes with Medicare or dual Medicare and Medicaid certification—about 86 percent of all homes. States are responsible for enforcing standards in homes with Medicaid-only certification—about 14 percent of the total. Enforcement actions can involve, among other things, requiring corrective action plans, imposing monetary fines, denying the home Medicare and Medicaid payments for new admissions until corrections are in place, and, ultimately, terminating the home from participation in these programs. Sanctions are imposed by CMS on the basis of state referrals. States may also use their state licensure authority to impose state sanctions.

CMS is also responsible for overseeing each state survey agency's performance in ensuring quality of care in its nursing homes. One of its primary oversight tools is the federal monitoring survey, which is required annually for at least 5 percent of all Medicare- and Medicaid-certified nursing homes. Federal monitoring surveys can be either comparative or observational. A comparative survey involves a federal survey team conducting a complete, independent survey of a home within 2 months of the completion of a state's survey in order to compare and contrast the findings. In an observational survey, one or more federal surveyors accompany a state survey team to a nursing home to observe the team's performance. Roughly 85 percent of federal surveys are observational. Based on prior work, we have concluded that the comparative survey is the more effective of the two federal monitoring surveys for assessing state agencies' abilities to identify serious deficiencies in nursing homes and have recommended that more priority be given to them. A new federal oversight tool, state performance reviews, implemented in October 2000, measures state survey agency performance against seven standards, including statutory requirements regarding survey frequency, requirements for documenting deficiencies, and timeliness of complaint investigations. These reviews replaced state self-reporting of their compliance with federal requirements. CMS also maintains a central database—the On-Line Survey, Certification, and Reporting (OSCAR) system—that compiles, among other information, the results of every state survey conducted at Medicare- and Medicaid-certified facilities nationwide.

Magnitude of Problems Remains Cause for Concern, Even Though Fewer Serious Nursing Home Quality Problems Were Reported

State survey data indicate that the proportion of nursing homes with serious quality problems remains unacceptably high, despite a decline in such reported problems since mid-2000. For an 18-month period ending in January 2002, 20 percent of nursing homes (about 3,500) were cited for deficiencies involving actual harm or immediate jeopardy to residents. This share is down from 29 percent (about 5,000 homes) for the previous period.[3] (Appendix I provides trend data on the percentage of nursing homes cited for serious deficiencies for all 50 states and the District of Columbia.) Despite this decline, there is still considerable variation in the proportion of homes cited for such serious deficiencies, ranging from about 7 percent in Wisconsin to about 50 percent in Connecticut.

Federal comparative surveys completed during a recent 21-month period found actual harm or higher-level deficiencies in about 10 percent fewer homes where state surveyors found no such deficiencies, compared to an earlier period. Fewer discrepancies between federal and state surveys suggest that state surveyors' performance in documenting serious deficiencies has improved. However, the magnitude of the state surveyors' understatement of quality problems remains a serious issue. From June 2000 through February 2002, federal surveyors conducting comparative surveys found examples of actual harm deficiencies in about one fifth of homes that states had judged to be deficiency free. For example, federal surveyors found that a home had failed to prevent pressure sores, failed to consistently monitor pressure sores when they did develop, and failed to notify the physician promptly so that proper treatment could be started. These federal surveyors noted that inadequate monitoring of pressure sores was a problem during the state's survey that should have been found and cited. CMS plans to hire a contractor to perform approximately 170 additional comparative surveys each year, bringing the annual total to 330, including those conducted by CMS surveyors.[4] We continue to believe that comparative surveys are the most effective technique for assessing state

[3]We analyzed OSCAR data for surveys performed from January 1, 1999, through July 10, 2000, and from July 11, 2000, through January 31, 2002, and entered into OSCAR as of June 24, 2002. Immediate jeopardy involves situations with actual or potential for death/serious injury.

[4]Contractor proposals are due to CMS on July 19, 2003.

agencies' ability to identify serious deficiencies in nursing homes because they constitute an independent evaluation of the state survey.[5]

Beyond the continuing high prevalence of actual harm or immediate jeopardy deficiencies, we found a disturbing understatement of actual harm or higher deficiencies in a sample of surveys that were conducted since July 2000 at homes with a history of harming residents but whose current surveys indicated no actual harm deficiencies. Overall, 39 percent of 76 surveys we reviewed had documented problems that should have been classified as actual harm: serious, avoidable pressure sores; severe weight loss; and multiple falls resulting in broken bones and other injuries. We were unable to assess whether the scope and severity of other deficiencies in our sample of surveys were also understated because of weaknesses in how those deficiencies were documented.

Weaknesses Persist in State Survey, Complaint, and Enforcement Activities

Despite increased attention in recent years, widespread weaknesses persist in state survey, complaint investigation, and enforcement activities. In our view, this reflects not necessarily a lack of effort but rather the magnitude of the challenge in effecting important and consistent systemic change across all states. We identified several factors that contributed to these weaknesses and the understatement of survey deficiencies, including confusion over the definition of actual harm. Moreover, many state complaint investigation systems still have timeliness problems and some states did not comply with HCFA's policy to refer to the agency for immediate sanction those nursing homes that showed a pattern of harming residents, resulting in hundreds of nursing homes not appropriately referred for action.

[5]In prior work completed on veterans' care in nursing homes, we recommended that the VA consider contracting with CMS to conduct these comparative surveys in order to better assess the quality of state data that are used in placing veterans in nursing homes. See U.S. General Accounting Office, *VA Long-Term Care: Oversight of Community Nursing Homes Needs Strengthening*, GAO-01-768 (Washington, D.C.: July 27, 2001). VA has not contracted with CMS to conduct comparative surveys but is beginning to discuss the issue with CMS.

Confusion about Definition of Harm and Other Factors Contribute to Underreporting of Care Problems

We identified several factors at the state level that contributed to the understatement of serious quality-of-care problems. State survey agency officials expressed confusion about the definitions of "actual harm" and "immediate jeopardy," which may contribute to the variability in identifying deficiencies among states. Several states' comments on our draft report underscored how the lack of clear and consistent CMS guidance on these definitions may have contributed to such confusion. For example, supplementary guidance provided to one state by its CMS regional office on how to assess the severity of a newly developing pressure sore was inconsistent with CMS's definition of actual harm.

Other factors that have contributed to the understatement of actual harm include lack of adequate state supervisory review of survey findings, large numbers of inexperienced surveyors, and continued survey predictability. While most of the 16 states we contacted had processes for supervisory review of deficiencies cited at the actual harm level and higher, half did not have similar processes to help ensure that the scope and severity of less serious deficiencies were not understated.[6] According to state officials, the large number of inexperienced surveyors, which ranged from 25 percent to 70 percent in 27 states and the District of Columbia and is due to high attrition and hiring limitations, has also had a negative impact on the quality of surveys. In addition, our analysis of OSCAR data indicated that the timing of about one-third of the most recent state surveys nationwide remained predictable—a slight reduction from homes' prior surveys, about 38 percent of which were predictable. Predictable surveys can allow quality-of-care problems to go undetected because homes, if they choose to do so, may conceal certain problems such as understaffing.

Many State Complaint Investigation Systems Still Have Timeliness Problems and Other Weaknesses

CMS's 2001 review of a sample of complaints in all states demonstrated that many states were not complying with CMS complaint investigation timeliness requirements. Specifically, 12 states were not investigating all immediate jeopardy complaints within the required 2 workdays, and 42 states were not complying with the new requirement established in 1999 to

[6]Officials explained the focus on actual harm or higher-level deficiencies by noting that the potential for sanctions increased the likelihood that the deficiencies would be challenged by the nursing home and perhaps appealed in an administrative hearing.

investigate actual harm complaints within 10 days.[7] Some states attributed the timeliness problem to an increase in the number of complaints and to insufficient staff. CMS also found that the triaging of complaints to determine how quickly to investigate each complaint was inadequate in some states. A CMS-sponsored study of the states' complaint practices also raised concerns about state approaches to accepting and investigating complaints. For example, 15 states did not provide toll-free hotlines to facilitate the filing of complaints and the majority of states lacked adequate systems for managing complaints. To address the latter problem, CMS planned to implement a new complaint tracking system nationwide in October 2002, but as of today, the system is still being tested and its implementation date is uncertain.

Substantial Number of Nursing Homes Were Not Referred to CMS for Immediate Sanctions

State survey agencies did not refer a significant number of cases where nursing homes were found to have a pattern of harming residents to CMS for immediate sanction as required by CMS policy, significantly undermining the policy's intended deterrent effect. Our earlier work found that nursing homes tended to "yo-yo" in and out of compliance, in part because HCFA rarely imposed sanctions on homes with a pattern of deficiencies that harmed residents.[8] In response, the agency required that, as of January 2000, homes found to have harmed residents on successive standard surveys be referred to it for immediate sanction.[9] While most states did not forward at least some cases that should have been referred under this policy, four states accounted for over half of the 700 nursing

[7]In March 1999, we reported that inadequate state complaint intake and investigation practices in states we reviewed had too often resulted in extensive delays in investigating serious complaints. As a result of our findings, HCFA began requiring states to investigate complaints that allege actual harm, but do not rise to the level of immediate jeopardy, within 10 working days. U.S. General Accounting Office, *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, GAO/HEHS-99-80 (Washington, D.C.: Mar. 22, 1999).

[8]See GAO/HEHS-99-46.

[9]This policy was implemented in two stages, and our analysis focused on implementation of the second stage beginning in January 2000. As of September 1998, HCFA required states to refer homes that had a pattern of harming a significant number of residents or placed residents at high risk of death or serious injury. Effective January 14, 2000, HCFA expanded this policy by requiring state survey agencies to refer for immediate sanction homes that had harmed residents on successive surveys. States are now required to deny a grace period to correct deficiencies without sanction to homes that are assessed one or more deficiencies at the actual harm level or above in each of two surveys within a survey cycle. A survey cycle is two successive standard surveys and any intervening survey, such as a complaint investigation.

homes not referred. One of these states did not fully implement the new CMS policy until mid-2002 and another state implemented its own version of the policy through September 2002, resulting in relatively few referrals. In most other states, the failure to refer cases resulted from a misunderstanding of the policy by both some states and CMS regional offices and, in some states, from the lack of an adequate system for tracking a home's survey history to determine if it met the policy's criteria.

CMS Oversight of State Survey Activities Requires Further Strengthening

While CMS has instituted a more systematic oversight process of state survey and complaint activities by initiating annual state performance reviews, CMS officials acknowledged that the effectiveness of the reviews could be improved. Major areas needing improvement as a result of the fiscal year 2001 review include (1) distinguishing between minor and major problems, (2) evaluating how well states document deficiencies, and (3) ensuring consistency in how regions conduct reviews. Data limitations, particularly involving complaints, and inconsistent use of periodic monitoring reports also hampered the effectiveness of state performance reviews. For subsequent reviews, CMS plans to more centrally manage the process to improve consistency and to help ensure that future reviews distinguish serious from minor problems.

Implementation has been significantly delayed for three federal initiatives that are critical to reducing the subjectivity in the state survey process for identifying deficiencies and determining the seriousness of complaints. These delayed initiatives were intended to strengthen the methodology for conducting surveys, improve surveyor guidance for determining the scope and severity of deficiencies, and increase standardization in state complaint investigation processes.

- **Strengthening the survey methodology**. Because surveyors often missed significant care problems due to weaknesses in the survey process, HCFA contracted in 1998 for the development of a revised survey methodology. The agency's contractor has proposed a two-phase survey process. In the first phase, surveyors would initially identify potential care problems using data generated off-site prior to the start of the survey and additional, standardized information collected on-site. During the second phase, surveyors would conduct an onsite investigation to confirm and document the care deficiencies initially identified. Compared to the current survey process, the revised methodology under development is designed to more systematically target potential problems at a home and give surveyors new tools to more adequately document care outcomes and conduct onsite investigations. In April 2003, a CMS official told us that the

agency lacked adequate funding to complete testing and implementation of the revised methodology under development for almost 5 years. Through September 2003, CMS will have committed about $4.7 million to this effort. While CMS did not address the lack of adequate funding in its comments on our draft report, a CMS official subsequently told us that about $508,000 has now been slated for additional field testing. This amount, however, has not yet been approved. Not funding the additional field testing could jeopardize the entire initiative, in which a substantial investment has already been made.

- **Developing clearer guidance for surveyors**. Recognizing inconsistencies in how the scope and severity of deficiencies are cited across states, in October 2000, HCFA began developing more structured guidance for surveyors, including survey investigative protocols for assessing specific deficiencies. The intent of this initiative is to enable surveyors to better (1) identify specific deficiencies, (2) investigate whether a deficiency is the result of poor care, and (3) document the level of harm resulting from a home's identified deficient care practices. Delays have occurred, and the first such guidance to be completed—pressure sores—has not yet been released.

- **Developing additional state guidance for investigating complaints**. Despite initiation of a complaint improvement project in 1999, CMS has not yet developed detailed guidance for states to help improve their complaint investigation systems. CMS received its contractor's report in June 2002, and indicated agreement with the report's conclusion that reforming the complaint system is urgently needed to achieve a more standardized, consistent, and effective process. CMS told us that it plans to issue new guidance to the states in late fiscal year 2003—about 4 years after the complaint improvement project initiative was launched.

Conclusions

As we reported in September 2000, continued federal and state attention is required to ensure necessary improvements in the quality of care provided to the nation's vulnerable nursing home residents. The proportion of homes reported to have harmed residents is still unacceptably high, despite the reported decline in the incidence of such problems. This decline is consistent with the concerted congressional, federal, and state attention focused on addressing quality of care problems. Despite these efforts, however, CMS needs to continue its efforts to better ensure consistent compliance with federal quality requirements. Several areas that require CMS's ongoing attention include: (1) developing more structured guidance for surveyors to address inconsistencies in how the scope and severity of deficiencies are cited across states, (2) finalizing and

implementing the survey methodology redesign intended to make the survey process more systematic, (3) implementing a nationwide complaint tracking system and providing states additional complaint investigation guidance, and (4) refining the newly established state agency performance standard reviews to ensure that states are held accountable for ensuring that nursing homes comply with federal nursing home quality standards. Some of these efforts have been underway for several years, with CMS consistently extending their estimated completion and implementation dates. The need to come to closure on these initiatives is clear. The report on which this testimony is based contained several new recommendations for needed CMS actions on these issues; CMS generally concurred with our recommendations.[10] We believe that effective and timely implementation of planned improvements in each of these areas is critical to ensuring better quality care for the nation's 1.7 million vulnerable nursing home residents.

Mr. Chairman and Members of the Committee, this concludes my prepared statement. I will be happy to answer any questions you may have.

Contact and Staff Acknowledgments

For further information about this testimony, please contact Kathryn G. Allen at (202) 512-7118 or Walter Ochinko at (202) 512-7157. Jack Brennan, Patricia A. Jones, and Dean Mohs also made key contributions to this statement.

[10] GAO-03-561.

Appendix I: Trends in The Proportion of Nursing Homes Cited for Actual Harm or Immediate Jeopardy Deficiencies, 1999-2002

	Number of homes surveyed			Percentage of homes cited for actual harm or immediate jeopardy			Percentage point difference[a]	
State	1/97-6/98	1/99-7/00	7/00-1/02	1/97-6/98	1/99-7/00	7/00-1/02	1/97-6/98 and 1/99-7/00	1/99-7/00 and 7/00-1/02
Alabama	227	225	228	51.1	42.2	18.4	-8.9	-23.8
Alaska	16	15	15	37.5	20.0	33.3	-17.5	13.3
Arizona	163	142	147	17.2	33.8	8.8	16.6	-25.0
Arkansas	285	273	267	14.7	37.7	27.3	23.0	-10.4
California	1,435	1,400	1,348	28.2	29.1	9.3	0.9	-19.9
Colorado	234	227	225	11.1	15.4	26.2	4.3	10.8
Connecticut	263	262	259	52.9	48.5	49.4	-4.4	0.9
Delaware	44	42	42	45.5	52.4	14.3	6.9	-38.1
District of Columbia	24	20	21	12.5	10.0	33.3	-2.5	23.3
Florida	730	753	742	36.3	20.8	20.1	-15.5	-0.8
Georgia	371	368	370	17.8	22.6	20.5	4.8	-2.0
Hawaii	45	47	46	24.4	25.5	15.2	1.1	-10.3
Idaho	86	83	84	55.8	54.2	31.0	-1.6	-23.3
Illinois	899	900	881	29.8	29.3	15.4	-0.5	-13.9
Indiana	602	590	573	40.5	45.3	26.2	4.8	-19.1
Iowa	525	492	494	39.2	19.3	9.9	-19.9	-9.4
Kansas	445	410	400	47.0	37.1	29.0	-9.9	-8.1
Kentucky	318	312	306	28.6	28.8	25.2	0.2	-3.7
Louisiana	433	387	367	12.7	19.9	23.4	7.2	3.5
Maine	135	126	124	7.4	10.3	9.7	2.9	-0.6
Maryland	258	242	248	19.0	25.6	20.2	6.6	-5.5
Massachusetts	576	542	512	24.0	33.0	22.9	9.0	-10.2
Michigan	451	449	441	43.7	42.1	24.7	-1.6	-17.4
Minnesota	446	439	431	29.6	31.7	18.8	2.1	-12.9
Mississippi	218	202	219	24.8	33.2	19.6	8.4	-13.5
Missouri	595	584	569	21.0	22.3	10.2	1.3	-12.1
Montana	106	104	103	38.7	37.5	25.2	-1.2	-12.3
Nebraska	263	242	243	32.3	26.0	18.9	-6.3	-7.1
Nevada	49	52	51	40.8	32.7	9.8	-8.1	-22.9
New Hampshire	86	83	79	30.2	37.3	21.5	7.1	-15.8
New Jersey	377	359	366	13.0	24.5	22.4	11.5	-2.1
New Mexico	88	82	82	11.4	31.7	17.1	20.3	-14.6
New York	662	668	671	13.3	32.2	32.3	18.9	0.2
North Carolina	407	414	419	31.0	40.8	30.1	9.8	-10.7
North Dakota	88	89	88	55.7	21.3	28.4	-34.4	7.1
Ohio	1,043	1,047	1,029	31.2	29.0	23.7	-2.2	-5.3
Oklahoma	463	432	394	8.4	16.7	20.6	8.3	3.9
Oregon	171	158	152	43.9	47.5	33.6	3.6	-13.9
Pennsylvania	811	788	764	29.3	32.2	11.6	2.9	-20.6

State	Number of homes surveyed			Percentage of homes cited for actual harm or immediate jeopardy			Percentage point difference[a]	
	1/97-6/98	1/99-7/00	7/00-1/02	1/97-6/98	1/99-7/00	7/00-1/02	1/97-6/98 and 1/99-7/00	1/99-7/00 and 7/00-1/02
Rhode Island	102	99	99	11.8	12.1	10.1	0.3	-2.0
South Carolina	175	178	180	28.6	28.7	17.8	0.1	-10.9
South Dakota	124	112	114	40.3	24.1	30.7	-16.2	6.6
Tennessee	361	354	377	11.1	26.0	16.7	14.9	-9.3
Texas	1,381	1,336	1,275	22.2	26.9	25.5	4.7	-1.5
Utah	98	95	95	15.3	15.8	15.8	0.5	0.0
Vermont	45	46	45	20.0	15.2	17.8	-4.8	2.6
Virginia	279	287	285	24.7	19.9	11.6	-4.8	-8.3
Washington	288	279	275	63.2	54.1	38.5	-9.1	-15.6
West Virginia	130	147	143	12.3	15.6	14.0	3.3	-1.7
Wisconsin	438	428	421	17.1	14.0	7.1	-3.1	-6.9
Wyoming	38	41	40	28.9	43.9	22.5	15.0	-21.4
Nation	**17,897**	**17,452**	**17,149**	**27.7**	**29.3**	**20.5**	**1.6**	**-8.8**

Source: GAO analysis of OSCAR data as of June 24, 2002.

[a]Differences are based on numbers before rounding.

Related GAO Products

Nursing Homes: Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature. GAO-03-187. Washington, D.C.: October 31, 2002.

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